STATE OF NEW YORK

PLANNING FOR THE CARE OF THE CHRONICALLY ILL IN NEW YORK STATE—SOME MEDICAL-SOCIAL AND INSTITUTIONAL ASPECTS

NEW YORK STATE COMMISSION
TO FORMULATE A LONG RANGE
HEALTH PROGRAM
also known as
NEW YORK (STATE)
HEALTH PREPAREDNESS COMMISSION

ALBANY
WILLIAMS PRESS, INC.
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LETTER OF TRANSMITTAL

ALBANY, NEW YORK

To His Excellency, the Governor of the State of New York, and to the Honorable Members of the Legislature of the State of New York:

The New York State Commission to Formulate a Long Range Health Program has the honor to submit for favorable consideration the report of its activities and investigations undertaken pursuant to the powers and duties conferred upon it by chapter 582 of the Laws of 1938, chapter 933 of the Laws of 1939, chapter 798 of the Laws of 1940, chapter 483 of the Laws of 1941, chapter 362 of the Laws of 1942, chapter 207 of the Laws of 1943, chapter 279 of the Laws of 1944 and chapter 255 of the Laws of 1945.

Respectfully submitted,

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Special Consultant USPHS

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ELSIE M. BOND, *Secretary*

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State Department of Social Welfare

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FOREWORD

The following report deals with some of the medical-social and institutional aspects of the over-all problem of planning for the care of the chronically ill in New York State. Based upon factual data and other pertinent material, it is a continuation of the Commission document which concerned itself with the regional aspects of such planning.[1] In view of the general interest in the boundaries of these proposed health service regions and suggested districts, a previously published map in which they are set forth following county lines is reproduced as Figure 7, page 131.

Among the elements considered in arriving at these tentative boundaries were: distribution of population, geography, transportation facilities, current administrative areas of departments and agencies, location of physicians in relation to the medical schools from which they graduated, natural flow of population seeking hospital care as measured by experience with public assistance patients, the flow of patients requiring hospitalization for the treatment of cancer, population flow with respect to teaching centers, and the present location of medical centers.

Impetus has been given to the implementation of the regional concept in health planning with the enactment by the 79th Congress of the Hospital Survey and Construction Act, Public Law 725, which had been introduced in Congress as Senate Bill 191. In our State, these boundaries have been provisionally applied as the basis for the hospital survey and plan of the Joint Hospital Board of the New York State Postwar Planning Commission.

Throughout its work the Commission has retained as a guiding principle the concept that since any proposed changes in the pattern of distribution of medical care must ultimately be applied at the local level, community conditions and reactions are of primary importance in evaluating the feasibility and workability of projected plans. It is only by carefully considering such factors in both rural and urban areas that any effective programs may eventually be evolved.

Realizing that there is no substitute for experience in the examination and appraisal of existing conditions as well as the formulation of considered judgments for their amelioration, local commissioners of public welfare and the administrators of general hospitals were invited to express their views concerning the existing provisions for the care of the chronically ill and the possible steps by which they might be improved, both from an immediate and long-range point of view. The State Department of Social Welfare has been consulted and kindly permitted certain information assembled through its staff in connection with nursing homes to be utilized by the Commission. The regulation of nursing homes in New York and other states has been the subject of inquiry. Finally, since a number of other states are officially planning for the care of the chronically ill, it was deemed desirable to carefully consider their activities so that New York State might receive the benefit of their research and experimentation.

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[1] Legislative Document (1945) No. 78A, *Planning for the Care of the Chronically Ill in New York State—Regional Aspects.*

The Commission has thus been profiting through the gracious cooperation of those who are concerned about and actually deal with the chronically ill, be it from a medical, nursing, institutional or social aspect. Meanwhile, certain phases of our inquiry reached a stage where they could be properly presented for preliminary discussion and consideration. Mimeographed reports were accordingly issued and circulated among the various individuals, groups and agencies, both official and voluntary, with whom the Commission has been in communication. The purpose of this was twofold, (1) to indicate the direction of the Commission's thinking and (2) to receive the benefit of any criticisms or suggestions that the ideas expressed might initiate. It was deemed necessary to present them in such a form that each pamphlet could be considered as complete within itself. There has been an unexpected demand for copies of these reports which are now out of print. In reprinting them herein, the Commission is cognizant that in certain minor instances references may be made to similar material in different portions of this report. However, it has seemed preferable to risk slight repetition and thus preserve the continuity and logic of presentation in the various sections so that each might be considered a coherent entity by the reader.

The volume of correspondence and comment received by the Commission relative to some of these sections originally distributed in mimeographed form are the best proof of the manner in which thinking concerning the problem of the chronically ill has been stimulated in the State, particularly at the local level. Very frequently this self-examination and appraisal of local conditions has had a beneficial effect upon community thinking and planning. It has become apparent, however, that although community action may be effective up to a certain point, the broader aspects of the problem require action on the State level for their eventual solution. Therefore, the Commission is devoting its energies to the formulation of a State program for the care of the chronically ill, giving due weight to local attitudes and autonomy and considering both State and local problems in their ramified relationships as parts of one whole.

The Commission is under deep obligation and wishes to express its appreciation to the great many individuals, institutions and agencies, both public and private, for their assistance in compiling information and suggestions in connection with the sections included in this report.

CARE OF THE CHRONICALLY ILL BETWEEN HOSPITAL AND HOME*

INTRODUCTION

Since the chronically ill can be cared for at home, in the hospital or in institutions intermediate between hospital and home, the place of care selected should depend largely upon the medical needs of the patient at the time. Whenever possible and medically expedient, an ill person should be cared for at home in the environment with which he is familiar and where he is more likely to be content. However, many of the chronically ill, although they do not require treatment in a hospital, do not have homes which can care for them properly. These must depend upon "between hospital and home facilities"—substitute homes such as convalescent or nursing homes, "sanatoria," county or city public homes, voluntary homes for the aged and supervised boarding homes.

Although the following presentation is devoted to a discussion of this intermediate type of care, it should be kept in mind that this is but one of several kinds of care needed by the chronically ill. They must be transferred from one variety of care to another, as their changing conditions demand. Therefore, a lack of proper between hospital and home facilities will create a "bottleneck" in making effective any comprehensive plan for the care of the chronically ill. For example, without such facilities many patients who might otherwise be discharged will be retained in general hospitals, thus depriving another patient of the opportunity of profiting from the hospital care which he needs. Similarly, a patient who cannot be cared for at home, yet who does not actually need the intensive medical service of a general hospital, may have to be hospitalized at relatively higher cost for want of more appropriate facilities.

The subsequent presentation is devoted to various existing facilities having potentialities for providing between hospital and home care of good quality. However, it is important to remember that they are not necessarily the only means of solution; for, as time goes on, it is quite possible that it will be found expedient to develop wings of general hospitals for this purpose, in addition to the between hospital and home facilities as we know them today.

THE PROBLEM

Whenever possible, and compatible with his medical needs, an ill person should be cared for at home. Many of the chronically ill may be partially or wholly ambulatory, may not require institutional or bedside care, may be self-directing and capable of remaining in their own homes, yet may need a sheltered, carefully planned mode of living. This would include continued medical supervision to maintain the highest level of physical performance possible for the patient, within the limitations imposed by the disease or disability. Approximately 85 per cent of the chronically ill probably can be cared for in their own homes. However, many patients cannot receive adequate care at home—those who need hospitalization or other institutional care and others who, not requiring institutional care, do not have homes capable of providing proper care. These are the responsibility of "between hospital and home facilities"—substitute homes such as convalescent or nursing homes, "sanatoria," county or city public homes and their infirmaries, voluntary homes for the aged, small proprietary hospitals and supervised boarding homes.

Between hospital and home facilities are neither purely medical nor social, but medical-social in character. Because they fall between these two fields of service they have not received the attention they deserve. Yet they are vital factors in providing care for the chronically ill and, in recent years, their numbers and aggregate capacities have increased greatly. It is, therefore, timely and in the public interest to examine more closely their present status, their potentialities and the methods by which they might be improved and encouraged to become a better integrated and more valuable part of the total gamut of facilities and services for the care of the chronically ill.

There are many reasons for their emergence: the growing demand for medical and medical domiciliary care; the general lack of preventive education in the geriatric field; the increasing proportion of the aged in the general population; the decreasing sense of responsibility of relatives in caring for their kin; and the tendency of families, especially those in urban areas, to reside in compact living quarters. These factors, among others, have created the demand for medical, nursing and custodial services outside the patient's own home.

Providing Quality Care

Eventually we must estimate the extent and specific kind of care needed for the adequate care of the chronically ill; ascertain the existing resources available; suggest means by which current facilities and services can be expanded, modified and adapted to meet the demand; and determine the additional facilities and services required.

Since the chronically ill come from all economic strata, any planning inevitably must take into consideration not only the present but the possible future composition of this group. In New York State facilities today are inadequate in both volume and quality to meet the needs of most persons able to pay for their care. In contrast to today's aged, chronically ill, medically indigent patients who have exhausted their savings in paying for a prolonged period of active medical

*A summary of some of the problems in providing adequate care for the chronically ill "between hospital and home" and suggestions for their solution. This material was previously published in mimeographed form by the Commission in 1946.

service, their counterpart of tomorrow will be individuals who, at age 65, will be collecting Old Age and Survivor's Insurance benefits paid for during a lifetime of work and payroll deductions, and who also are likely to be carrying hospitalization insurance. Though these will be only one group among the chronically ill, and although their benefits may be limited, they will be able to pay modest charges in full, or somewhat higher fees in part. This aspect of our Social Security Law was established on the theory that it would preserve a sense of independence in old age. The development of proper facilities and services for such citizens, therefore, would fulfill the obligation of making that independence a reality. As a first step, since many of the chronically ill require between hospital and home facilities, the discussion which follows deals with institutions which, on the whole, are regarded as potentially capable of providing this much needed service.

SOURCES OF INFORMATION

The subsequent discussion is limited to nursing and convalescent homes, supervised boarding homes, public homes and voluntary homes for the aged, information being available on these facilities. These are frequently used for the placement of public charges[1] and, as a group, care for the majority of those ill persons regarded as needing institutional care but not hospitalization.

In addition to the more general references cited, the factual data, concepts and conclusions presented specifically relative to New York State are primarily based on a synthesis of (1) studies made by the Health Preparedness Commission; (2) material previously prepared and distributed by the Commission to individuals assisting in planning for the care of the chronically ill; and (3) conferences of the Commission staff with informed local individuals. The method and extent of coverage of local areas of New York State is shown in Figure 1, page 17, and Table 1, pages 18 and 19. Much of the supporting material is included in the following list:

I. *Studies made and officially published by the Health Preparedness Commission.*[2]

1. Health and Medical Care, Niagara County, New York, 1944.
2. Health and Medical Care, Ontario County, New York, 1944.
3. Health and Medical Care, Seneca County, New York, 1944.
4. Health and Medical Care, Washington County, New York, 1944.

II. *Material prepared by the Commission, mimeographed and distributed to individuals assisting in planning for the care of the chronically ill.*

5. Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill, (in cooperation with the New York State Association of Public Welfare Officials), 1945. (Reprinted infra, pages 37 to 60, under the title Care of the Chronically Ill—The Local Public Welfare Viewpoint.)
6. A Study of Nursing Homes in New York State, 1943, May 1946. (Reprinted infra, pages 107 to 121.)
7. Regulation of Nursing Homes in New York State, September 1946. (Reprinted infra, pages 122 to 131.)
8. Licensure of Nursing Homes in Other States, September 1946. (Reprinted infra, pages 87 to 103.)
9. Official Planning for the Care of the Chronically Ill in Other States, May 1946. (Reprinted infra, pages 74 to 87.)

III. *Conferences of the Commission staff with informed local individuals.*

10. The Commission staff interviewed approximately 87 public welfare and public health officials, responsible practitioners and persons engaged in community planning in 15 counties and 11 cities in upstate New York, (September and October 1945). See Figure 1, page 17, and Table 1, pages 18 and 19.

IV. *Other sources of information.*

11. Statistical data on nursing homes certified by local departments of public welfare, as of July 1945, which were made available by the New York State Department of Social Welfare.
12. New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, Medical Care in New York State, 1939, Legislative Document (1940) No. 91, 1940.

[1] "Public charge" includes all persons whose care is provided wholly or partially at public expense.

[2] Printed individually and subsequently reprinted in the *1943–1944 Report of the New York State Commission to Formulate a Long Range Health Program* (New York State Health Preparedness Commission), Legislative Document (1944) No. 56A, 1945.

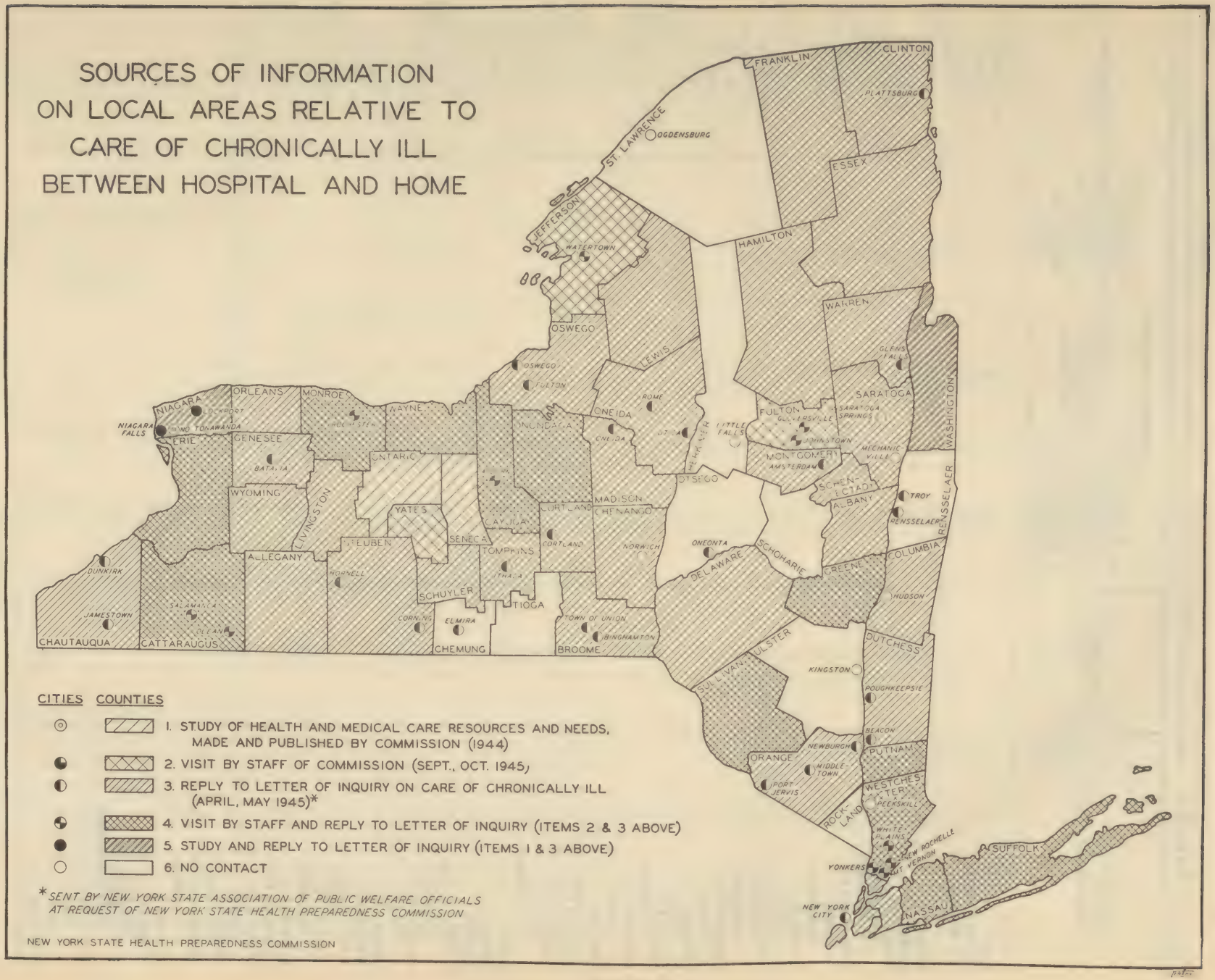
SOURCES OF INFORMATION
ON LOCAL AREAS RELATIVE TO
CARE OF CHRONICALLY ILL
BETWEEN HOSPITAL AND HOME
CITIES COUNTIES
1. STUDY OF HEALTH AND MEDICAL CARE RESOURCES AND NEEDS, MADE AND PUBLISHED BY COMMISSION (1944)
2. VISIT BY STAFF OF COMMISSION (SEPT., OCT. 1945)
3. REPLY TO LETTER OF INQUIRY ON CARE OF CHRONICALLY ILL (APRIL, MAY 1945)*
4. VISIT BY STAFF AND REPLY TO LETTER OF INQUIRY (ITEMS 2 & 3 ABOVE)
5. STUDY AND REPLY TO LETTER OF INQUIRY (ITEMS 1 & 3 ABOVE)
6. NO CONTACT
*SENT BY NEW YORK STATE ASSOCIATION OF PUBLIC WELFARE OFFICIALS AT REQUEST OF NEW YORK STATE HEALTH PREPAREDNESS COMMISSION
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION
FRANKLIN
CLINTON
PLATTSBURG
ST. LAWRENCE
OGDENSBURG
ESSEX
JEFFERSON
WATERTOWN
HAMILTON
WARREN
OSWEGO
LEWIS
SARATOGA
WASHINGTON
NIAGARA
ORLEANS
MONROE
WAYNE
ONEIDA
ROME
FULTON
MONTGOMERY
SCHENECTADY
ALBANY
TROY
RENSSELAER
COLUMBIA
GREENE
HUDSON
ERIE
GENESEE
ONTARIO
WYOMING
LIVINGSTON
YATES
SENECA
CAYUGA
CORTLAND
MADISON
CHENANGO
OTSEGO
DELAWARE
SCHOHARIE
ONEONTA
NORWICH
TOMPKINS
ITHACA
TIOGA
SCHUYLER
ELMIRA
CORNING
CHEMUNG
ALLEGANY
HORNELL
STEUBEN
DUNKIRK
JAMESTOWN
CHAUTAUQUA
CATTARAUGUS
BROOME
TOWN OF UNION
BINGHAMTON
ULSTER
KINGSTON
SULLIVAN
DUTCHESS
POUGHKEEPSIE
BEACON
NEWBURGH
PUTNAM
ORANGE
MIDDLETOWN
PORT JERVIS
ROCKLAND
WESTCHESTER
PEEKSKILL
WHITE PLAINS
NEW ROCHELLE
MT. VERNON
YONKERS
NEW YORK CITY
NASSAU
SUFFOLK

FIGURE 1

TABLE 1. *Sources of Information on Local Areas Relative to the Care of the Chronically Ill*

WELFARE DISTRICT	Information Obtained	Source of Information			No Information Obtained
		Reply to Written Inquiry Sent Local Commissioner of Public Welfare Relative to Care of the Chronically Ill (April 1945)	Interviews of Commission Staff with Representative Local Personnel (Sept., Oct. 1945)	Study Made and Published by Health Preparedness Commission on Local Health and Medical Care, Resources and Needs (1944)	
Total[1]	89	83	26	7	17
County districts	48	43	15	4	9
City districts	41	40	11	3	8
Albany Co	x	x	.....	.....	.....
Allegany Co	x	x	.....	.....	.....
Broome Co	x	x	.....	.....	.....
Binghamton	x	x	.....	.....	.....
Union (town)	x	x	.....	.....	.....
Cattaraugus Co	x	x	x	.....	.....
Olean	x	x	x	.....	.....
Salamanca	x	x	x	.....	.....
Cayuga Co	x	x	x	.....	.....
Auburn	x	x	x	.....	.....
Chautauqua Co	x	x	.....	.....	.....
Dunkirk	x	x	.....	.....	.....
Jamestown	x	x	.....	.....	.....
Chemung Co	.....	.....	.....	.....	x
Elmira	x	x	.....	.....	.....
Chenango Co	x	x	.....	.....	.....
Norwich	.....	.....	.....	.....	x
Clinton Co	x	x	.....	.....	.....
Plattsburgh	x	x	.....	.....	.....
Columbia Co	x	x	.....	.....	.....
Hudson	.....	.....	.....	.....	x
Cortland Co	x	x	.....	.....	.....
Cortland	x	x	.....	.....	.....
Delaware Co	x	x	.....	.....	.....
Dutchess Co	x	x	.....	.....	.....
Beacon	x	x	.....	.....	.....
Poughkeepsie	x	x	.....	.....	.....
Erie Co	x	x	x	.....	.....
Essex Co	x	x	.....	.....	.....
Franklin Co	x	x	.....	.....	.....
Fulton Co	x	.....	x	.....	.....
Gloversville	x	x	x	.....	.....
Johnstown	x	x	x	.....	.....
Genesee Co	x	x	.....	.....	.....
Batavia	x	x	.....	.....	.....
Greene Co	x	x	x	.....	.....
Hamilton Co	x	x	.....	.....	.....
Herkimer Co	.....	.....	.....	.....	x
Little Falls	.....	.....	.....	.....	x
Jefferson Co	x	.....	x	.....	.....
Watertown	x	x	x	.....	.....
Lewis Co	x	x	.....	.....	.....
Livingston Co	x	x	.....	.....	.....
Madison Co	x	x	.....	.....	.....
Oneida	x	x	.....	.....	.....
Monroe Co	x	x	x	.....	.....
Rochester	x	x	x	.....	.....
Montgomery Co	x	x	.....	.....	.....
Amsterdam	x	x	.....	.....	.....
Nassau Co	x	x	x	.....	.....
Niagara Co	x	x	.....	x	.....
Lockport	x	x	.....	x	.....
Niagara Falls	x	x	.....	x	.....
North Tonawanda	x	.....	.....	x	.....
Oneida Co	x	x	.....	.....	.....
Rome	x	x	.....	.....	.....
Utica	x	x	.....	.....	.....
Onondaga Co	x	x	x	.....	.....
Ontario Co	x	.....	.....	x	.....

TABLE 1. *Sources of Information on Local Areas Relative to the Care of the Chronically Ill*

WELFARE DISTRICT	Information Obtained	Source of Information			No Information Obtained
		Reply to Written Inquiry Sent Local Commissioner of Public Welfare Relative to Care of the Chronically Ill (April 1945)	Interviews of Commission Staff with Representative Local Personnel (Sept., Oct. 1945)	Study Made and Published by Health Preparedness Commission on Resources and Local Health and Medical Care, Needs (1944)	
Orange Co	x	x			
Middletown	x	x			
Newburgh	x	x			
Port Jervis	x	x			
Orleans Co	x	x			
Oswego Co	x	x			
Fulton	x	x			
Oswego	x	x			
Otsego Co					x
Oneonta	x	x			
Putnam Co	x	x	x		
Rensselaer Co					x
Rensselaer	x	x			
Troy	x	x			
Rockland Co					x
St. Lawrence Co					x
Ogdensburg					x
Saratoga Co	x	x			
Mechanicville					x
Saratoga Springs					x
Schenectady Co	x	x			
Schoharie Co					x
Schuyler Co	x	x			
Seneca Co	x			x	
Steuben Co	x	x			
Corning	x	x			
Hornell	x	x			
Suffolk Co	x	x	x		
Sullivan Co	x	x	x		
Tioga Co					x
Tompkins Co	x	x			
Ithaca	x	x			
Ulster Co					x
Kingston					x
Warren Co	x	x			
Glens Falls	x	x			
Washington Co	x	x		x	
Wayne Co	x	x	x		
Westchester Co	x	x	x		
Mt. Vernon	x	x	x		
New Rochelle	x	x	x		
Peekskill					x
White Plains	x	x	x		
Yonkers	x	x	x		
Wyoming Co	x	x			
Yates Co	x		x		
New York City	x	x			

[1] During 1945 there were 106 local welfare districts, 57 county and 49 city districts.

CONVALESCENT CARE

The active medical service required during an acute illness or an acute exacerbation of a chronic illness is usually provided either in the patient's own home or in a hospital. As partial recovery or maximum immediate benefit from intensive medical care is obtained, consideration should be given to completing the patient's restoration to full health or, if this is not possible, to attaining the maximum arrest of the disease and preparing him for return to as useful a life as possible within the limitations of his handicap.

Purpose of Convalescence

This is the convalescent stage, the period between the subsiding or arrest of a disease and as complete a restoration to health as is possible. Planning for it should begin while active treatment is still progressing and, whenever medically feasible and socially desirable, should include a regime for return to independent earning power through rehabilitative training. The convalescent period, although it may be protracted, is temporary, being terminated by the onset of either (a) full recovery or (b) partial recovery, or at least improvement over the status on admission. If neither full nor partial recovery or improvement seems likely, the patient is not a suitable candidate for convalescent care, but may require medical domiciliary care. The length of time needed for convalescence varies with specific disease entities, individual capacity for recuperation and the status of medical knowledge. The term "convalescence" in association with chronic illness is used deliberately for, even though most of the chronically ill may be incapable of achieving full recovery in a relatively brief period, many can improve somewhat over a longer period and some may be restored to full health with proper aids to convalescense. For example, the convalescent periods following a heart attack, rheumatic fever, thyroid surgery, a recurrent hernia, a fractured thigh, severe diabetes, ulcerative colitis and an amputation associated with diabetes are generally prolonged, yet often result in marked improvement and close approximation to normal health.

The Welfare Council of New York City has estimated that half of the patients discharged from convalescent homes in New York City in 1933 were suffering from a chronic disease.[3] Of 850 patients admitted in 1941 to one convalescent home,[4] operated in close affiliation with a large, voluntary general hospital, at least 284 (one-third) suffered from a chronic disease. The duration of stay of all patients ranged from 17 to 77 days, the average being 23 days. The stay of the chronic patients did not greatly exceed this average.

The criteria of admission for a patient with chronic disease to this convalescent home are three-fold: (1) he must be sufficiently ambulatory to permit walking to the bathroom and dining room, (2) he must be considered capable of some improvement in health and (3) he must be "actually ready for discharge from the hospital." The liberality of these admission requirements is evident from the fact that the patients admitted included some who needed intra-muscular injections or surgical dressings, patients with colostomies and post-operative patients with advanced cancer.

Admittedly, the prognoses of some of the chronically ill are poor, even verging on the need for terminal care. However, when there is reason to believe that there is a possibility of improvement, the chronically ill should be given an opportunity to respond to proper convalescent care of high quality before being classified as custodial cases, probably destined to spend their ensuing years as non-productive members of society. Anything less would seem defeatist, anti-social and, considered in the light of our aging population and productive manpower needs, uneconamical. This was emphasized by Mr. Lawrence Frank who, at the Conference on Convalescence and Rehabilitation sponsored by the New York Academy of Medicine, stated: "We are going to have more old people with more chronic illness, which is now coming earlier in life. . . . We are also becoming aware that neglected convalescence is one of the largest contributing factors to premature aging as well as to the fixation of chronic illness."[5]

The need for and value of proper convalescence must be understood by the layman, who is at once the consumer, the philanthropic contributor and the taxpayer. It should be accepted and advocated more widely by practicing physicians and its place in total medical planning for the individual patient should receive greater emphasis in medical education. Physicians generally have given insufficient consideration to ascertaining the needs of patients following the period of intensive medical service, have not prescribed and supervised a clear cut regime of convalescence and have not concertedly insisted that the community provide proper facilities and services for this purpose. Had they done so, it is likely that well organized convalescent facilities and services would today be more available, relapses of patients less frequent, their re-admissions to hospitals less numerous and restoration to earning power more rapid and complete.

Where Provided

Whenever possible, convalescent care should be provided in the patient's own home, supplemented, if necessary, by such community resources as visiting nurse, housekeeper and rehabilitation training services. Yet a number of factors make it impossible for some homes properly to provide this care: the patient may be living alone with no one to care for him; the home

[3] Mary C. Jarrett, *Chronic Illness in New York City*, Welfare Council of New York City, Columbia University Press, 1933. 2 vol.

[4] The Neustadter Home for Convalescents of Mt. Sinai Hospital, New York City. See *Report of Subcommittee on Convalescence of the Committee on Chronic Illness*, Welfare Council of New York City, October 1942. (Mimeographed).

[5] New York Academy of Medicine, *Convalescence and Rehabilitation*, New York, 1944, p. 142.

may be physically inadequate or overcrowded; the family may be incapable of carrying out instructions; too specialized nursing care may be required; the adult members of the household may all be employed, leaving no one to care for the patient; or the patient himself may be a difficult personality more responsive to instructions from relative strangers than from his own family. Under such circumstances care may have to be provided in between hospital and home facilities.

The possibility of providing convalescent care at home, even under difficult circumstances, and in specialized institutions is illustrated in the following cases:

> When an intelligent, adolescent boy, recovering from osteomyelitis involving both legs, was ready for hospital discharge late in the spring, his condition required frequent changes of dressings and daily exposure to the sun for specified periods. No convalescent home capable of changing the dressings was available. His parents, who lived in a slum district and spoke no English, had little understanding of American customs and no appreciation of the value of convalescent care. They were adamant against convalescent home placement. The attending physician, cognizant of the boy's intelligence and sense of responsibility, instructed the lad on the regime to be followed—lying in the sun daily in bathing trunks on an accessible roof and returning to the hospital clinic periodically for a change of dressings and continued medical supervision. Convalescence progressed normally during the ensuing summer months, the boy attended school in the winter and, during the following summer, went to a specially selected camp, all the while seeing the physician periodically. Convalescence was uneventful and successful.

This indicates that, even when home conditions may be partially adverse, proper convalescence can be achieved when the physician clearly outlines the regime and the patient has the capacity to understand and carry out instructions.

> It was impossible to locate a nursing or convalescent home which would admit and change the dressings of a 36 year old, diabetic Negro woman following amputation of one leg above the knee. Therefore, upon discharge from the hospital, the patient returned to her own home, was taught by a visiting nurse to prepare her diet and give herself insulin and returned to the hospital clinic periodically for a change of dressings. The patient's morale was shattered, there was no incentive to live. This state of mind was due to her inability to simultaneously accommodate herself to a new handicap and assume numerous new responsibilities —restrictions on food, preparation of a special diet, injection of insulin and limitations of locomotion caused by the amputation. In fact, pending healing of the limb, there was a question as to the advisability of buying an artificial leg and trying to teach the patient to use it. As soon as the need for dressings ended, the clinic physicians ordered the patient to a convalescent home in the country, a final attempt to restore morale. The patient was relieved of some responsibilities, the surroundings were pleasant and, even though insulin was still self-injected, the home prepared the diet and also showed the patient how she might more easily prepare it for herself in the future. Physical and mental recovery were rapid, the artificial leg was purchased and was soon being used adeptly by the patient.

This case shows the role of convalescent care in relieving a patient of some responsibilities, bolstering her morale and thus facilitating accommodation to physical and dietary limitations.

> A very elderly, white-haired Negro preacher had suffered a double amputation, one above and one below the knee. He was determined to walk again but the sympathetic hospital medical staff considered him far too old. Because of his helplessness he was sent to a convalescent home. However, the preacher's small and poor congregation, undismayed, raised funds for one artificial limb and money towards the second—and then the hospital contributed the rest. Surprisingly, and despite his age, the patient did use the artificial limbs, his proudest moment being the first Sunday when he again stood behind the pulpit preaching to his loyal congregation.

This is an example of the contribution of character and sheer willpower to convalescence, while the following case illustrates an adaptation to medical domiciliary care.

> A progressively arthritic patient, now 45, was admitted to a nursing home as a young girl directly from college. Now almost helpless and never physically able to be discharged, although receiving adequate medical attention, the patient pays part of her care from earnings from a rather large greeting card business conducted by telephone.

Convalescent care, wherever provided, should include proper nutrition to overcome the ravages of disease, fresh air, sunshine, recreation and pleasant surroundings, combined with medical supervision and service, nursing care, occupational therapy and rehabilitative training, as required. These are the interdependent and interrelated nutritional, physical and psychological factors needed to restore physical and mental health and spiritual well-being and to prevent human atrophy, economic dependence and a "what's the use" state of mind.

Medically Economically and Socially Sound

Properly organized convalescence, wherever provided, is medically, economically and socially sound. This was demonstrated during the recent war by the rapidity with which our armed forces were able to return casualties to full combat duty or, for those to be discharged from service, to independent earning power. Among a group of atypical pneumonia cases the Army Air Forces found that, with unsupervised convalescence, 45 days hospitalization and a 30 per cent recurrence rate resulted, whereas, under a planned convalescent program, only 31 days hospitalization and a three per cent recurrence rate occurred.[6] The community workshop in Boston, sponsored by the Liberty Mutual Life Insurance Company to provide vocational rehabilitative training to its convalescent compensation cases, has effected a net saving of benefits, reflecting a shortening of the convalescent period and restoration to independent earning power.[7] The study of Weiskotten, Jensen and Thomas has shown that intelligent medical follow-up of patients discharged from a hospital ward prevented relapses and the subsequent need for rehospitalization.[8]

Similarly, proper convalescent care conserves hospital resources and increases their effectiveness. When a close administrative relationship, including an inter-

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[6] *Ibid.*, p. 83.

[7] *Ibid.*, p. 61.

[8] H. G. Weiskotten, Frode Jensen and Margaret A. Thomas, *Medical Care of the Discharged Hospital Patient*, New York. The Commonwealth Fund, 1944.

change of records and opinions, exists between a hospital and a convalescent home of high quality, patients can readily be discharged from the former to the latter. In this way continuity of medical care is maintained and the benefits of costly hospital service are not reduced by indifferent after-care. Further, since such a working agreement assures the home of the hospital's backing and its willingness quickly to readmit a patient, when necessary, it is possible for the convalescent home to have a flexible and liberal admission policy.

Standards of Care

Convalescent care, to be truly effective, must be of such quality as to offer the maximum opportunity to the patient for rehabilitation and return to a period of economic usefulness and happiness. On the other hand, it is not hospital care. The type of institutional facility which is considered necessary to furnish true convalescent care may be guaged from the following criteria formulated and published by the Subcommittee on Convalescence of the Committee on Chronic Illness, Welfare Council of New York City:[9]

1. *Location:* preferably in the country and not more than one hour's travelling distance from an affiliated hospital.

2. *Affiliation with a general hospital* by means of:
   (a) having several members on the boards of both institutions;
   (b) direction of the convalescent home by a physician who is on the staff of the hospital;
   (c) interchange of medical records; and
   (d) a regular procedure for transfer of patients from the hospital to the home, or from the home to the hospital, if necessary.

3. *Physical plant:* Grounds ample for mild exercise and recreation. Separate wings for male and female patients with administrative, surgical, recreational and occupational therapy facilities in a part of the building connecting the two wings. Adequate toilet facilities, in the ratio of one toilet for every seven patients, with extra individual lavatories for colostomy patients, in each wing. Wards preferably not larger than four beds each, with some single and double rooms. A minimum of 50 beds in all. An examining room or surgery for examinations and treatments. Adequate provision for recreational and occupational therapy.

4. *Professional staff:*
   (a) An attending physician who visits the home twice a week, sees each patient at least once a week, is on call for emergencies and is notified at once regarding any unexpected changes in a patient's condition.
   (b) Registered nurses in the ratio of one to each 16 patients. One attendant.
   (c) A trained dietician.
   (d) A trained occupational therapist.

[9]Welfare Council of New York City, *op. cit.*

Comparison With Great Britain

In comparison with Great Britain, organized convalescent care in the United States seems to have attained neither the same volume nor the same acceptance as an important, integral part of medical care. In 1930 there were in the United States 7.1 convalescent beds per 100,000 population distributed over 179 institutions, with approximately 60 per 100,000 needed, while Britain had 53.6 per 100,000 located in 343 institutions. The British convalescent homes are an outgrowth of need, beginning in the eighteenth century, and stem from three major factors: (1) a large part of the British population lived in overcrowded unsanitary housing in the 1700's and 1800's, necessitating their admission to hospitals when ill; (2) hospital expansion did not meet the continued demand for beds and it became necessary to discharge patients early, either to their own homes or, when these were unsuitable, to alternate places of care; and (3) the more recent demand by clinicians and public health officials for convalescent care as part of the preventive medicine program. Although Britain's housing has improved in the intervening years, its social consciousness has also grown and, more recently, standards of medical care have risen markedly. The demand for convalescent care has, therefore, continued. By the early 1930's the British trend was toward establishing government operated convalescent homes rather than increasing the number of homes under philanthropic and mutual assistance auspices, the sponsorships under which this service first developed.[10]

These factors are being duplicated in this country, though belatedly. The overcrowded housing situation, among other factors, is causing many ill persons to seek admission to hospitals; the demand for hospital beds is necessitating early discharges, even in an era when new therapies and drugs are decreasing the average length of hospital stay; and the clinician's desire that his discharged patient receive maximum benefit from the intensive medical service provided during hospitalization is creating an appreciation of, and demand for, proper convalescent care. The analogy may go even further. Since the number of convalescent beds in this country falls far below need, since philanthropic funds are now less readily available and since, historically, we tend to meet widespread health and social welfare needs through public auspices, it seems likely that eventually we may provide convalescent care through government, especially for those unable to pay for service.

The Situation in New York City

The most current, authoritative information on convalescent homes in New York City, as distinguished from nursing homes, is reported in a study

[10]Elizabeth G. Gardiner, *Convalescent Care in Great Britain*, Chicago, University of Chicago Press, 1935.

sponsored by several interested local groups and recently published by the Hospital Council of Greater New York.[11] The following data are from this source.

The number of convalescent homes in New York City in 1930 represented almost half the total in the United States. However, even under such seemingly favorable circumstances, and in the absence of a study of needs, it is not certain that the number of beds in New York City are sufficient in volume or quality to meet the demand. From 1935 to 1944 the number of homes declined from 53 to 38, the number of beds from 3,443 to 2,567 and the beds per 100,000 population from 47.20 to 33.67. During this period the number of beds for adults and children in general convalescent homes decreased, while those for cardiac patients in special convalescent homes increased 76.6 per cent. Although all the reasons for closure of homes are not recorded, it is noted that many succumbed to war-wrought problems of operation. During approximately this same period the homes had a fairly constant average annual occupancy rate of about 80 per cent. In this connection, it is interesting that high occupancy rates were associated with the homes of larger size, those receiving public charges and those having resident or regularly visiting physicians.

Detailed data for both the convalescent homes and their patients were reported for 1940. All 46 homes were under church or non-sectarian auspices. Two-thirds of the aggregate 3,223 beds were in general and the remainder in special convalescent homes (cardiac, orthopedic, neurological). Moreover, almost three-fifths of all the beds were for children. As a group, the 46 homes provided 944,436 days of care to 26,281 patients during the year. Although there were homes with less than 25 beds each and others with over 150 beds, the average capacity per home was approximately 72 beds.

From the fact that almost three-quarters of the patients were referred by general hospitals and another 10 per cent by social and health agencies, it seems evident that the value of organized convalescent care is rather widely recognized by such organizations. Analysis of the pay status of the patients in 1940 indicates that only one-fifth were wholly or partially financially self-sufficient.

Pay Status	*Per Cent Distribution*	
	Patients	*Days of Care*
Total	100.0	100.0
Full-pay	6.7	5.2
Part-pay	13.9	10.9
Public charges	28.9	45.6
Free	50.5	38.3

The cost of care of public charges was paid by official welfare and health agencies while that of free patients was met by endowment funds of the homes, contributions and monies from financial federations. The average stay per patient was two to three weeks for adults and a little under four weeks for children under care in general convalescent homes. Both free patients and those who paid their own way, in whole or in part, tended to stay a shorter period than those who were public charges. This may be related to the greater liberality of public welfare agencies and of funds available to them, or to the higher proportion of cardiac and orthopedic cases among the public charges, two types of cases staying for protracted periods.

The Situation in Upstate New York

In New York City is it possible to obtain data which distinguish between convalescent and nursing homes because of information continuously gathered by such organizations as the Hospital Council and United Hospital Fund. Unfortunately, similar information is not available for upstate New York as a whole. There is neither a national organization which appraises these facilities in the same way that the American Medical Association and the American College of Surgeons survey hospitals, nor is there official statewide licensure or inspection service applicable to all convalescent homes. They are most often confused with nursing homes, the same institution providing either both services or more often, the latter only. However, the general impression exists, unsubstantiated by a study or survey, that there are relatively few bonafide convalescent homes in upstate New York.

MEDICAL DOMICILIARY CARE

Convalescent vs. Medical Domiciliary Care

The foregoing discussion has dealt with convalescence to emphasize the need for proper care for those of the chronically ill who are capable of complete or partial recovery, or restoration to limited activity despite a physical handicap. However, others of the chronically ill, incapable of such recovery, become custodial cases. They must be cared for indefinitely either in their own homes or in medical domiciliary institutions designed for this purpose. The distinction between the convalescent, including the long-term convalescent, and the custodial care cases is not clearly defined today, nor are places for their care differentiated through clearly stated functions and admission policies. Except in a few large urban centers having a wide range of highly specialized facilities, both types of cases depend largely on public homes and so-called nursing homes for care. These accept patients (1) requiring a planned convalescence, (2) requiring temporary nursing care under general medical supervision, (3) needing nursing service for long periods and (4) requiring either custodial or terminal care. Unless such a home is of especially high quality, it is not likely that each of these types of patients will receive the care their conditions demand. Moreover, senile patients having psychotic and cerebral arteriosclerotic impairments, as well as chronic alcoholics,

[11] Elizabeth G. Gardiner and Francisca K. Thomas, *The Road to Recovery from Illness*, Hospital Council of Greater New York, 1945. (Sponsors of the study: Committee on Public Health Relations of the New York Academy of Medicine, New York City Department of Hospitals, Hospital Council of Greater New York, United Hospital Fund of New York, Welfare Council of New York City.)

are frequently found in both nursing homes and public homes. The result is a heterogeneous grouping of patients and a tendency to provide similar care for all, too often only the custodial type of care. The service provided is too frequently devoid of personalized attention based on sound medical recommendations designed to achieve successful physical and mental convalescence, restoration to earning power or, for custodial cases, a reasonably happy life.

Potential Facilities It is evident that an adequate program for the care of the chronically ill requires two types of service between hospital and home—convalescent and medical domiciliary. Whether such services will be provided in separate facilities or in different units of the same institution is a decision inherent in long range planning.

The convalescent institution can play an important role in achieving the greatest possible rehabilitation of chronically ill patients. However, there appears little prospect that any considerable number of such institutions will be established in upstate New York in the near future, especially in the less densely populated sections of the State. Therefore, in the absence of suitable convalescent homes in this area, the following possibilities exist: (1) Convalescent care might be part of the care provided in the long-term care wing of the general hospital; (2) it might be provided in a voluntary (non-profit) convalescent home established contiguous to and as a part of a valuntary general hospital; (3) it might be provided in a public "custodial" or "medical domiciliary" institution, such as a county nursing home; (4) it might be provided in a proprietary nursing home; (5) it might be provided in the infirmary of a voluntary home for the aged; or (6) it might be provided in the patient's own home.

A wing of the general hospital caring for long-term patients is neither the ideal nor the most economical place for such care. A county nursing home, on the other hand, could provide such care for the chronically ill if its facilities and staff were adequate. However, in utilizing the county nursing home for this purpose, it should be stressed and reiterated that the case of each patient should be reviewed periodically to determine the possibility of his discharge, either to his own home or to some other more appropriate place of care. Ideally, institutional convalescent care should be given in institutions especially designed for the purpose. Since such care chronologically and medically follows that given in general hospitals, the most reasonable development would be that of institutions which would be, in effect, extensions of such hospitals.

NURSING HOMES

For purposes of discussion, a nursing home is regarded as one providing shelter, board and nursing care and services under medical supervision to sick, infirm or handicapped persons not in need of hospitalization.

Many of the medically indigent chronically ill are cared for in nursing homes which also admit paying patients. Therefore, information on the homes caring for the indigent gives a general picture of the types of homes available to, and used by, a majority of the general population. Public welfare officials generally patronize neither the very poor quality nor the very expensive nursing homes, but the average homes.

Study Made by State Department of Social Welfare In 1943, local departments of public welfare requested the New York State Department of Social Welfare to reimburse for care in nursing homes without first exacting "prior approval." The department, to secure information as a basis for consideration of the proposal, gathered data on the situation by the sampling method.[12]

Findings. Relatively few of the local departments of public welfare which had placed relief recipients in the 109 nursing homes studied had a clear conception of the relationship of nursing home care to medical care in general, or of the quality of service provided. The homes generally accepted the convalescent, the chronically ill, the aged and the infirm but, with scattered exceptions, excluded alcoholic, cancer, infectious disease and mental cases and post-operative patients requiring considerable care. Most of the homes had urban locations. Most presented fire hazards, were small (only one-third could accommodate 20 or more patients) and were operating at almost full capacity. Only one-half had been at their present locations for three years or longer. Although they were reported as having comfortable beds, adequate space between beds, sufficient bed clothing, suitably lighted rooms and necessary ventilation, a majority lacked the facilities and equipment requisite for proper care. The study did not attempt to evaluate the quantity or quality of the medical and nursing care provided, but did note that the homes were generally negligent in keeping records, that only one-third had registered nurses and that the remainder relied on either practical nurses or untrained personnel. The prevailing monthly rates were $25 to $45 in New York City and $40 to $65 in upstate New York.

Half of the 1,362 patients under care in the homes studied were recipients of public assistance, 80 per cent of whom were 65 years old and over and most were women. Contrary to previous impressions, the relief recipients generally had not been placed in the nursing homes immediately following hospitalization. More than two-thirds were cardio-vascular, neurological, psychiatric, rheumatic, metabolic, glandular or vitamin deficiency cases; and an appreciable number showed evidence of some mental condition—senility, forgetfulness, confusion, childishness. One-half had been placed in the respective nursing homes

[12]Reported in *A Study of Nursing Homes in New York State*, 1943, New York State Health Preparedness Commission, May 1946. (Reprinted infra, pages 107 to 121.) (The basic data collected and tabulated by the State Department of Social Welfare were interpreted and published in mimeographed form by the Commission, with the official approval of the Department.)

solely for medical and the remainder for social or medical-social reasons. The majority had been in the present homes less than one year.

Conclusions. One outstanding conclusion of the medical social workers and institutional inspectors making the study was that a patient may be perfectly satisfied and content in a nursing home entirely inadequate from every standpoint relating to minimum standards of care. This would indicate that the morale of individual patients, a vital factor in recovery, is probably closely related to the attitude of the proprietor and staff, the accessibility of the nursing home to the patients' friends and relatives, and the similarity of the nursing home to the patient's previous environment.

The homes studied differed widely in quality, were neither universally satisfactory nor unsatisfactory, but could not, as a group, be considered proper institutions for ill persons. The preponderance of aged persons under care, many with poor prognoses, indicated that the volume of convalescent care provided was negligible. Even under these circumstances the demand for beds exceeded supply. As a result, local welfare officials, obligated to place patients at rates their respective communities were willing and able to pay, could not be too selective in their choice of homes for placement.

From an administrative viewpoint, the nursing homes had received no appreciable leadership in integrating their service with those of the total public medical care program; and no well-defined policy of State reimbursement for nursing home care had been established. The wide range of quality, the transitory nature of many locations and the extremely commercial attitude of some operators, had created reluctance to place increasing reliance on nursing homes as a medical resource, without simultaneously encouraging the establishment of alternate facilities for care of both the medically indigent and those patients able to pay for service.

Subsequent action. The State Department of Social Welfare reports [13] that the findings of the study resulted in the Department's (1) officially defining a nursing home for purposes of reimbursement (September 1944), thereby insuring State financial participation in the costs of care for the medically indigent in nursing homes; (2) establishing nursing home care as a medical item, reimbursable only when recommended by the attending physician; and (3) removing ceilings from rates reimbursable by the Department.[14]

Such reimbursement was made contingent upon the local department of public welfare certifying the nursing homes used; and, although minimum standards for this purpose were suggested, they were not mandatory. According to the State Department of Social Welfare, the process of certification (1) made it possible for the Department to establish a file of nursing homes used locally for recipients of public assistance (July 1945); (2) caused State and local public welfare officials to become more aware of the problems and cost involved in providing nursing home care; and (3) made State and local welfare officials conscious of the role of nursing homes in a medical program, and of the need for increasing their adequacy.

Number of Homes in 1945 and 1946

From July 1945 to May 1, 1946, a period of ten months, the number of nursing homes certified for use by the local commissioners of public welfare rose from 400 homes with 5,110 beds to 447 homes with 6,139 beds, an increase of 12 per cent in the number of homes and 20 per cent in the number of beds. Since the 1945 data were assembled just before the end of World War II and the 1946 data eight months following cessation of hostilities, the rise indicates that the demand for nursing home beds is increasing and is not solely related to such war-wrought factors as family dislocations and shortages of nurses, physicians and hospital beds. Moreover, in October 1946, when 425 nursing homes were certified by local commissioners of public welfare, the Division of Vital Statistics, New York State Department of Health, had an additional 419 homes listed (exclusive of known tuberculosis cottages) wherein deaths from tuberculosis and cancer had occurred or from which cases of cancer had been reported—making an unduplicated total of 844 nursing homes. Undoubtedly there are many more homes in the State but their number is unknown as there is no all-inclusive roster thereof.

Additional data on nursing homes certified by the local commissioners (July 1945) are presented in Tables 2 and 3.[15] Although less than a quarter of the nursing homes had accommodations for 20 or more patients each, their combined capacities accounted for more than half that of the entire group of homes. The prevailing rates in upstate New York were $60 and $90 and those in New York City $80 to $125 per month—a sharp contrast to the 1943 findings showing rates of $40 to $65 upstate and $25 to $45 in New York City. State participation in the cost of care, with certification as a prerequisite, the general increasing awareness of the nursing home problem and demand for beds exceeding supply probably were factors in this rise. There was no definite correlation between the monthly rates of a home and its size. However, when large homes, which can spread overhead costs more widely, tend to have the same rates as small operations (under five beds), the question arises as to the quality of care in the latter.

[13] In a letter from Commissioner Robert T. Lansdale, New York State Department of Social Welfare, to the New York State Health Preparedness Commission, May 17, 1946.

[14] New York State Department of Social Welfare, *Reimbursable Care in a Private Nursing Home* (Bulletin No. 105), September 19, 1944. (Reprinted infra, pages 117 to 121.)

[15] Data adapted from unpublished tabulations provided by the New York State Department of Social Welfare, 1945.

TABLE 2. *Number and Bed Capacity of Nursing Homes Used by Local Departments of Public Welfare in New York State, July 1945*

BED CAPACITY	HOMES		BED CAPACITY	
	Number	Per Cent Distribution	Number of Beds	Per Cent Distribution
Total	[1] 400	100.0	[2] 5,110	100.0
Under 5 beds	93	23.3	250	4.9
5– 9 beds	109	27.2	755	14.8
10–19 beds	109	27.2	1,442	28.2
20–34 beds	71	17.8	1,712	33.5
35 beds and over	18	4.5	951	18.6

[1] Ten homes with 341 beds were in New York City and the remainder in upstate New York.
[2] Exclusive of the bed capacity not reported on one home.

TABLE 3. *Number of Nursing Homes Used by Local Departments of Public Welfare in New York State, Exclusive of New York City, by Maximum Monthly Rate and Bed Capacity of Home, July 1945*

MAXIMUM MONTHLY RATE	Total Homes	NUMBER OF HOMES					
		Under 5 Beds	5–9 Beds	10–19 Beds	20–34 Beds	35 Beds and Over	No Report
Total	390	93	108	108	66	14	1
Under $50	41	8	16	10	5	2	.....
$50–59	34	13	12	5	4	.....	.....
60–69	112	46	28	23	14	1	.....
70–79	118	12	26	39	32	9	.....
80–89	38	7	12	14	4	.....	1
90–99	8	1	2	3	1	1	.....
100–124	12	1	4	4	3	.....	.....
125–149	2	.....	1	1	.....	.....	.....
150–174	15	4	5	6	.....	.....	.....
175 and over	9	.....	2	3	3	1	.....
Not reported	1	1	.....	.....	.....	.....	.....

Controls

In addition to public opinion, there are several well known controls which, if properly administered, may be expected to promote and maintain safe, sanitary and adequately equipped nursing homes capable of providing a good quality of care. These controls are: (1) reimbursement for care of recipients of public assistance on the basis of established and enforced standards, (2) licensure of nursing homes, and (3) critical selection of homes by agencies using them.

Reimbursement for Care of Public Charges. Since some of the patients in many nursing homes are public charges, the quality of the service required by the official welfare agencies for their care may be effective in determining the quality of these homes. As the same home frequently admits both the medically indigent and those able to pay for care, the latter will benefit from the standards of care exacted for the former. However, when demand for nursing home beds exceeds supply, proprietors can choose their clientele and may reject relief recipients for whom they might be required to provide a high quality of service. Conversely, when bed supply exceeds demand, the same proprietors are anxious to admit relief recipients and are, therefore, more amenable to meeting the standards required. One should not lose sight of the fact that in periods when nursing homes welcome the medically indigent, cared for at public expense, the patients able to pay for care may be forced to patronize either the homes with rates considered too high by welfare officials or those not chosen by them because of the poor quality of care provided. Thus, although the practice of reimbursement is helpful, it does not uniformly raise the standards of all nursing homes.

As previously stated, the New York State Department of Social Welfare now reimburses local departments of public welfare for nursing home care without "prior approval," but has not required that mandatory criteria be applied by these departments in certifying nursing homes. The responsibility for judging the nursing homes has been placed on local welfare officials, many of whom do not have staff personnel competent to assume this assignment. Concurrently, the Department, as a policy, has neither assigned staff to make such inspections upon local request nor assisted the local units in developing properly qualified personnel for this service. There is, therefore, no uniformity among the homes used in the various localities and no consistent minimum standards of care. Consequently, the quality of care varies from community to community in relation to local social-mindedness, competency and financial ability. Although there is little doubt that State financial participation has improved the quality of nursing home care provided the medically indigent, it is equally true that mandatory, rather than suggested, criteria prerequisite for reimbursement, supplemented with leadership in establishing local inspection services of high quality, would ensure better results and the development of a competent factual basis for future planning.

Licensure. Nursing homes in states, counties or cities covered by licensure systems must, as a condition of operation, fulfill requirements specified in local ordinances, or state laws, and the regulations of the administering agency. Homes are usually licensed under one of three general methods: (1) licensure systems applying to nursing homes only, i. e., wherein this type of facility is defined and then required to meet the requirements set forth; (2) licensure of homes caring for the aged, which is tantamount to licensing nursing homes since such homes either care for some aged persons, among others, or wish to be permitted to do so; and (3) comprehensive licensure systems covering all types of institutions caring for ill persons. In the latter, each facility is classified as to type (general hospital, special hospital, maternity hospital, convalescent home, nursing home, etc.) and is then obligated to meet the requirements set forth for the particular classification assigned. Licensure may be applicable to a town, city, county or an entire state, depending upon the geographical jurisdiction of the body passing the enabling legislation.

In New York State licensure systems specific for nursing homes exist in Mt. Vernon, New Rochelle, New York, Syracuse, Yonkers and Nassau County, the local departments of health being the licensing agencies, except in New York City where the Department of Hospitals is responsible. In general, the nursing home operator must file an application; the home is inspected by the licensing agency, often in cooperation with the local fire, building and zoning authorities; and the license is granted if the prescribed conditions are met. The published requirements of these communities tend to emphasize safety and sanitation standards rather than those relating to the quality of medical and nursing care provided.[16]

When licensure covers only a limited local area, homes can escape regulation by moving a short distance beyond the geographical jurisdictional line. When it is on a county basis, inspectional jurisdiction is divided between county and local officials, local (town, village, city) fire marshals and building inspectors passing on the fire safety and structural aspects of licensure and the county acting relative to the sanitation, nursing and medical aspects of care. This division of authority results in a wide variation of standards within a single county.[16]

Although they do not have licensure systems, Buffalo and White Plains exercise a legal control over nursing homes through their respective lodging house ordinances. The Consolidated Health District of Saranac Lake and Harrietstown has regulations addressed to the standardization of sanatoria, especially those accepting tuberculosis cases. In Rochester, the registration of proprietary hospitals, sanatoria, nursing homes and convalescent homes is mandatory, subsequent inspection of these institutions is optional with the Commissioner of Saftey and non-conformance to published regulations punishable.[16]

At least 20 states have laws licensing nursing homes.[17] The fact that such legislation was passed in 14 of these states within the last five years indicates that these facilities are exciting concern and a demand that they provide a quality of service concomitant with the public interest. In eight states the laws are comprehensive, covering virtually all institutions caring for ill persons.[18] The respective state departments of health are the licensing agencies in 12 states, and always where licensure is comprehensive; while the departments of welfare are responsible in seven states, including five wherein licensure is specifically directed to the protection of the aged.[19] This indicates a tendency to assign the supervision to the health unit when coverage is comprehensive or directed to nursing homes generally, and to the welfare unit when licensure is directed more specifically to the care of the aged.[20]

The usual procedure in licensing these institutions is that the operator files an application, the state licensing agency inspects the premises and, if the home meets the standards specified, grants a license. The state agency often solicits the cooperation of the official state and local health, welfare, fire, building and zoning authorities in making its determination, and frequently requires that homes submit for approval any plans for new construction or material remodeling. The requirements most commonly made cover construction, safety, sanitation (including food), accommodations, equipment, admission policies, records and reports; while those addressed to the quality of service provided are less frequent and usually less precise. In fact, a review of the enabling legislation, rules and regulations of the respective states lends credence to the impression that licensure in many instances is primarily concerned with the physical plant and sanitation, rather than the quality of care provided. There are exceptions. New Jersey maintains a continuing supervisory relationship with each nursing home, resulting in their progressive improvement;[21] North Dakota offers assistance in studying the need for new homes in any particular locality and advocates a cooperative, continuing consultant service to proprietors; and New Jersey and Missouri enforce specific requirements addressed to promoting continuing medical care to patients in nursing homes.[22]

Selection of Homes on Basis of Criteria. Organizations placing a number of individuals in nursing homes can, individually or collectively, establish their own criteria and select for their patients those homes meeting their specifications. This is true of such agencies as local public welfare departments, private family welfare agencies, home visiting nurse associations, social service departments of hospitals and similar agencies. From a realistic viewpoint, this method has the effect of boycotting homes not meeting requirements. When the supply of nursing home beds in a community exceeds demand, this method is effective; but when demand exceeds supply, nursing homes are not as dependent on such organizations for referrals and, consequently, are not as likely to strive to fulfill the criteria.

This unofficial method has been used in Monroe County, New York. In 1937 the County Department of Public Welfare wished to determine what constituted a "good" nursing home since it had to provide

[16]New York State Health Preparedness Commission, *Regulation of Nursing Homes in New York State*, mimeographed Sept. 1946. (Reprinted infra, pages 122 to 131.)

[17]California, Colorado, Connecticut, Delaware, Illinois, Indiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota and Texas.

[18]California, Colorado, Connecticut, Maine, Maryland, Minnesota, Oklahoma, South Dakota.

[19]In addition, the State Department of Institutions and Agencies is the licensing department in New Jersey.

[20]New York State Health Preparedness Commission, *Licensure of Nursing Homes in Other States*, mimeographed Sept. 1946. (Reprinted infra, pages 87 to 103.)

[21]*Ibid.* Also see *Official Planning in Other States for the Care of the Chronically Ill*, New York State Health Preparedness Commission, mimeographed May 1946. (Reprinted infra, page 84.)

[22]New York State Health Preparedness Commission, *Licensure of Nursing Homes in Other States*, mimeographed Sept. 1946. (Reprinted infra, pages 87 to 103.)

care for some aged and chronically ill persons who, although not needing hospitalization, could not be cared for properly in their own homes. Neither local licensure nor any similar local control of nursing homes existed; and no State agency inspected nursing homes or had suggested standards for them. Yet, because of general public demand, nursing homes were springing up "like mushrooms." Therefore, a local, voluntary committee[23] was formed to evaluate the problem, make suggestions and act as a unit. Minimum nursing home standards were formulated; a nurse was employed to inspect the homes used by the various participating agencies, with full approval of the proprietors; and the findings were considered by the committee. Subsequently the homes were classified as to type and quality, a register of acceptable homes for use of local agencies was established and subsequent inspections were made.[24] After two years the committee disbanded and the service became part of the program of the County Department of Public Welfare, which ultimately used this experience in officially establishing requirements for nursing homes wherein clients of the Department were placed.[25]

Although this method is effective, its benefits redound only to agencies and persons cooperating in using only those homes considered suitable, it is subject to the interaction of supply of and demand for beds, and it fails to safeguard the public as a whole.

The Current Situation

In discussing the nursing home situation with informed State and local official and non-official persons in the social welfare, public health, medical care and community organization fields, the following conclusions were reached: (1) Many of the nursing homes in the State are poorly housed, equipped and staffed and frequently provide a poor quality of care. (2) Many nursing homes are too small to assure adequate care at reasonable rates. (3) The demand for nursing home beds so far exceeds the supply that extremely low grade homes must too often be used and those of better quality can charge, and get, fees beyond the financial capacity of most persons. (4) There is a lack of continuity of medical service in many of the homes. (5) The services of most homes are not correlated with other local medical services and are not closely associated with general hospitals. (6) Little effort is made by the homes to rehabilitate the patients physically and mentally and thus enable them to resume more normal and productive lives in the community.

Local commissioners of public welfare, although specifically concerned with caring for the medically indigent, are close to local situations and are, therefore, in a position to report on them as they affect the total community. The following are quoted from a few of many replies received from such officials.

> "Our so-called nursing and convalescent homes are inadequate. They are understaffed and not properly equipped to provide extensive bedside care for chronic cases. They are willing to accept the infirm and homeless who require a minimum of care but those admitted are mostly ambulatory. In this sense they are but glorified boarding homes."[26]—From letter of Department of Public Welfare of Montgomery County, May 3, 1945, signed by Roland Hoffman, Commissioner.
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> "In the City of Buffalo and the County of Erie, we have encountered considerable difficulty in finding nursing and convalescent homes for our welfare cases, due to the fact that private nursing and convalescent homes are receiving fees way beyond the amounts the County is allowed to pay. Private nursing homes in this vicinity are receiving $25 to $60 per week, whereas we are only allowed to pay from $50 to $60 per month."[27]—From letter of Department of Social Welfare of Erie County, April 19, 1945, signed by Thomas W. H. Jeacock, Commissioner.
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> "The average nursing home gives care only in the daytime although a great many of the patients are just as much in need of nursing care at night. I have failed to find the nursing home which gives this kind of service. Furthermore, such homes have neither the equipment nor staff to give proper care. On the other hand, the county home is well equipped for 24-hour service seven days a week and also has the services of a licensed physician, as needed. Therefore, I am convinced that the problem must be solved by establishing public infirmaries to give the care and attention now needed and which, most assuredly, will be needed even more in the future."[28]—From letter of Department of Public Welfare of the Town of Union, April 6, 1945, signed by H. B. Osterhout, Commissioner.
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> "We are being called upon more and more by individuals from the community for advice and help in locating nursing homes for members of their families who are chronically ill, but for whom care at public expense is not needed. It is a problem to know how far this service should be developed when we realize that there are no over-all standards or supervision of nursing homes, and no control over the type of care offered by private nursing homes. We feel this service is implicit in our duties as a public welfare department, but we would, however, feel more confident in meeting this problem if there were a more effective means of licensing nursing homes, which would assure at least minimum standards of care and of equipment for meeting the needs of the patients."[29]—From letter of Department of Public Welfare of Westchester County, May 29, 1945, signed by Ruth Taylor, Commissioner.

On the whole, the nursing homes in New York State are lacking in quality, are not fulfilling their expected role in convalescent care, are tending to provide only a custodial type of service in caring for the chronically ill and are not a dynamic, integral part of the total medical service in the State. Conferences of the Commission staff with informed local persons have indicated that public sentiment favors eventual State regulation of nursing homes.

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[23]With representation from the Monroe County and Rochester City Departments of Public Welfare, Rochester Public Health Nursing Association, Rochester Council of Social Agencies, New York State Department of Social Welfare, New York State Department of Health and a superintendent of a local nursing home.

[24]Stella M. Perryman, *An Approach to the Private Nursing Home Problem in Monroe County*, 1941. (Mimeographed).

[25]Monroe County Department of Public Welfare, "Nursing Home Care," *Monroe County Medical Care Manual*, 1941 (revised 1945).

[26]New York State Association of Public Welfare Officials in cooperation with the New York State Health Preparedness Commission, *Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill*, mimeographed May 1946. (Reprinted infra as Care of the Chronically Ill—The Local Public Welfare Viewpoint, page 42.)

[27]*Ibid.*, page 42.

[28]*Ibid.*, p. 45.

[29]*Ibid.*, p. 45.

The existence of serious problems regarding nursing homes is further indicated by a recent statement of the Chairman of the Joint Hospital Board of New York State:

> "As a result of problems arising with the use of nursing homes by the State Department of Mental Hygiene, the nursing home problem was discussed at a meeting of the Joint Hospital Board on February 4, 1946. It was decided that the Departments of Mental Hygiene, Social Welfare and Health all have responsibilities in the area of nursing homes which can be met more satisfactorily by joint inter-departmental action. Consequently, the Board voted to proceed with consideration of the nursing home problem in the State."[30]

Conclusions and Suggested Recommendations

Regulation of standards and facilities of nursing homes is needed. It should apply to all nursing homes, and should be on the State level to obviate problems of jurisdiction between counties and within counties, and to insure a high quality of inspection service to communities financially or otherwise unable to provide such service. One of two methods suggest themselves: (1) comprehensive licensure of all institutions caring for ill persons including nursing homes; or (2) regulation of nursing homes only. In this connection, one speculates as to the effect upon New York State if a number of adjacent states establish comprehensive licensure. Would this action tend to drive sub-standard facilities to New York State, if the latter lacked regulation?

Comprehensive licensure seems the desirable method for New York State to adopt as its long range objective in promoting a high quality of medical and nursing home care. However, if this method of regulation were not established at an early date, it would seem advisable immediately to initiate some method of regulation addressed to nursing homes only; but this is clearly a second and alternate choice.

On the basis of the foregoing presentation the following principles are suggested in considering, formulating, establishing and administering statewide official regulation of nursing homes:[31]

1. Regulation should apply to all nursing homes, regardless of whether under proprietary, voluntary or public auspices.
2. When their facilities and staffs permit, local official agencies (county or city) should have the option of administering the regulatory process within their respective jurisdictions, under State formulated minimum standards.
3. Inspections relative to the sanitation, fire safety and structural standards should be made by the State or local official departments technically qualified and legally responsible for these aspects of the public safety. Preferably, such departments should assign proper personnel for this purpose to the enforcement agency.
4. Inspections of nursing homes should be made by a "team" of specialists, each member thereof to be qualified by training and experience to pass judgment on those aspects of regulation coming within his respective field of competency. The "team" should visit a nursing home as a group, its members should consult each other to insure consistency of conclusions and should submit a composite report.
5. Specific minimum standards should be formulated, published and distributed and should be applicable to each nursing home in the State. Such standards should include those relative to admissions and quality and continuity of medical and nursing care, as well as those relative to physical structure, fire safety, sanitation, accommodations, equipment and facilities.
6. Any method of regulation established should be legally capable of deterring the opening of any new nursing home which, on the basis of data and structural plans submitted by the potential operator (individual, association, church group, fraternal order or governmental unit), is adjudged incapable of meeting the established minimum standards of operation.
7. The State administrative agency should be just as responsible for teaching and assisting the nursing homes as for censuring them, i.e., in addition to formulating and enforcing standards it should offer constructive consultative and advisory service, upon request, to those nursing homes wishing to improve their operations.
8. The administrative responsibility should include the obligation to maintain records to insure a continuing basis of study of the nursing home situation and the regulatory process so that both might constantly be improved, on the basis of fact.
9. The nature of any regulatory process established should take cognizance of the manpower situation as it relates to the administrative staff, i.e., it should ensure complete coverage of nursing homes regarding details considered of fundamental importance and, instead of "spreading thin" on other aspects of regulation, should concentrate its efforts on those aspects most beneficial to the public interest.
10. Enforcement of regulations must be so executed as to preclude the closing of nursing homes when alternate facilities do not exist for placement of the patients who would thus be displaced.

In order to secure the maximum attainable benefit in setting and raising standards, allowing opportunity for teaching administrators of nursing homes and permitting public authorities to obtain current information, a system of registration, combined with the power to formulate and enforce regulations, would seem a suitable method for improving the quality of nursing homes in New York State, particularly under currently prevailing circumstances. This would allow for the application of the preceding principles, would avoid the rigidity inherent in the traditional licensure system and would meet the objection that licensure would merely close down facilities which, though far from ideal, are better than nothing at all.

If licensure were the method of regulation chosen, the licensing agency would be legally obligated to inspect *each* nursing home probably annually or, less preferably, biennially. If qualified personnel were not readily available, the administering agency might have to "spread thin" its inspection service to reach each home, thus attenuating the quality of inspection of all homes. Registration would obviate such a legal responsibility.

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[30] From letter of Robert T. Lansdale, Chairman, Joint Hospital Board of New York State, to the New York State Health Preparedness Commission, May 17, 1946.

[31] Previously published in *Regulation of Nursing Homes in New York State*, New York State Health Preparedness Commission, mimeographed Sept. 1946. (Reprinted infra, pages 122 to 131.)

The following are envisioned as the major characteristics of registration:[32]

1. A certificate of registration would be required to be posted in every nursing home in the State as a condition of operation.
2. Certificates of registration would carry no expiration date and would be valid for an indefinite period, subject to revocation for cause.
3. On or before the effective date of registration, each nursing home in the State would be required to file with legally designated officials a completed official application for a certificate of registration, the administrative agency automatically approving all such applications.
4. Upon filing the completed application form, each such registrant (nursing home) would receive a copy of the minimum standards for operation of nursing homes, fulfillment of which would be requisite to continued operation.
5. Subsequently, the administrative State agency would inspect those nursing homes in which inspection seemed most needed and, if necessary, could effect improvement through (a) offering advice and consultation; (b) placing the registrant on probation; (c) fine the offender, subject to appeal; or (d) revoke the certificate of registration, subject to appeal.

   (It should be noted that the administrative agency would not be obligated to inspect each nursing home at specified intervals, but could, if limitations of personnel require, deploy its manpower to inspect and advise those homes which, in the public interest, seemed to demand immediate attention. Others could be brought under purview as the situation demanded and/or the availability of qualified staff allowed.)
6. Each individual or group contemplating the establishment of a nursing home would be required, as a condition of opening, to file a completed, official application for a certificate of registration, accompanied by specified data, including structural plans. Approval of such applications by the enforcement agency would be based on a determination of the applicant's ability to meet the established minimum standards.
7. Plans for new construction or remodeling, the increasing of the bed capacity and the amendment of admission policies of any nursing home should be subject to approval of the enforcement agency.

The use of the registration method as a means of regulation could effectively fulfill the principles previously suggested. Although its staff probably would be unable to visit all nursing homes at the outset, the administrative agency gradually and systematically could achieve complete coverage, at the same time providing consultative and advisory service. It should dedicate itself to quality, not merely quantity, performance.

SUPERVISED BOARDING HOMES

Closely related to the nursing home is the "supervised boarding home," a term occupying no niche in the social work, medical or public health glossaries. It has sprung up spontaneously and concurrently in a number of localities in New York State to describe a home approved by a local department of public welfare to provide shelter, board and personal services to sick, handicapped or infirm persons not in need of hospitalization or nursing home care, yet unable to resume normal living.

These homes have arisen because of bed shortages in general hospitals, the lack of beds and rising rates of nursing homes, an aging population and an increasing demand for care for ambulatory persons unable to care for themselves without assistance. A supervised boarding home is an approved boarding home whose proprietor is willing occasionally to assist the boarder with such services as dressing, combing the hair, tying shoes or serving a tray in bed. Professional nursing service is not needed and, when medical care is required, the boarder visits his physician's office or a clinic.

Some local departments of public welfare tend to use supervised boarding homes as a substitute for nursing homes. In practice, this frequently is a subterfuge for, if a home is classified as a supervised boarding home rather than as a nursing home, certification thereof is not a prerequisite for State reimbursement.

Although supervised boarding homes seem to have been developed to meet the immediate demand during wartime, evidence points to their continuance and increase, often encouraged by local departments of public welfare. They are an asset, providing a protected, homelike environment for ambulatory aged and/or ill persons who have no suitable homes of their own and who are neither sufficiently ill nor handicapped to require medical domiciliary, nursing home or hospital care. As the individual boarder's physical condition varies he may need nursing home care and, conversely, the nursing home patient may improve sufficiently to "graduate" to the supervised boarding home, thus setting up an interflow of individuals among various types of facilities meeting the needs of the moment.

The emerging importance of the supervised boarding home, its place in the gamut of facilities and the services it should provide are reported in a recent paper describing such homes in Monroe County.[33] In addition, the New York City Department of Public Welfare has made a study of such homes used by its clients as a basis for developing policies, standards and budgetary schedules relative to boarding home care.[34] These are but two examples expressing a trend—the acceptance of boarding home care for handicapped individuals, mildly ill persons and the realization that demand therefor is increasing.

If these trends are prophetic, it may be incumbent upon the State to protect the aged and the ill in the selection of boarding homes, just as it now guards children in the choice of foster homes. The aged and ill, like children, often need protection, cannot speak for themselves too effectively and frequently are

[32] *Ibid.*

[33] Jean V. Masters, *Developing the Formulae for Suitable Housing for the Aged—The Boarding Home.* Presented at the New York State Conference on Social Work, Rochester, Nov. 1944.

[34] New York City Department of Public Welfare, *Study of Boarding Homes*, 1945.

financially dependent upon government. Therefore, the State Department of Social Welfare might assume leadership in formulating minimum standards for those supervised boarding homes accommodating public charges whose care it wholly or partially reimburses. Moreover, this service might ultimately be extended to the non-dependent aged and ill. Local welfare units, under leadership from the State Department, might set up rosters of supervised boarding homes meeting the specified standards and make such registers available to the non-dependent, upon request.[35] Standards for such homes might be established and applied now in localities where there is no housing shortage, and to others as their respective housing situations improve.

PUBLIC HOMES

In discussing the public homes and their infirmaries, the Commission wishes only to present its concept as to the place of these institutions relative to care for the chronically ill. A more detailed analysis of these facilities will undoubtedly be made by the Subcommittee on Adult Institutional Care of the Special Committee on Social Welfare and Relief of the New York Joint Legislative Committee on Interstate Cooperation.

There are approximately 23,000 general hospital beds in upstate New York approved by the American Medical Association; over 6,000 beds in the upstate nursing homes certified by local commissioners of public welfare, only a part of which are used by public charges; and in 1944 there were 12,593 beds, including 3,002 infirmary beds, in the 60 upstate public homes.[36] This indicates the number of beds in the latter institutions as compared with those in the other two types of strictly medical or medically related facilities. In 1943 the upstate public homes cared for 14,318 persons, about one-third of whom were under 65 years of age, with almost three times as many men as women.

No detailed analysis of the physical condition of these patients has been made, no widespread attempt to classify them diagnostically has been initiated and there has been no concerted effort to ascertain the types of care required by them, on the basis of their individual physical condition and social situation. However, the findings of other states should give some indication as to what a detailed study in New York State might reveal. A study of public homes in Illinois, made in 1945 by the Illinois Public Aid Commission, indicated that four-fifths of the population of these homes was in need of continuous nursing service and medical care.[37] A similar study of county homes made in 1939 in Maryland, including medical and psychiatric examinations, revealed that 62.2 per cent of the inmates were chronically ill and required nursing and medical care, and that an additional 18.6 per cent required care in mental hospitals—a total of 81.2 per cent of the public home population.[38]

Data assembled by the Health Preparedness Commission on public charges known to the Nassau County Department of Public Welfare in 1944 indicate (1) that 71 per cent of the patients in the County Home were chronically ill and (2) that two-thirds of the days of care provided by the Home were to chronically ill patients. Of 235 persons studied who were served by the Home in 1944, 64.7 per cent suffered from some chronic illness, 20.4 per cent had an illness not classified as chronic and 14.9 per cent were undiagnosed and, presumably, were not ill.[39]

Therefore, without knowing the exact proportion today in New York State, it might be assumed that its public homes likewise care for a high proportion of ill persons, most of them chronically ill.

Additional credibility is given to this assumption by a study made by the Health Preparedness Commission of first admission forms submitted to the State Department of Social Welfare by the public homes of upstate New York for 1938. This analysis showed that almost half the admissions (49.5 per cent) were for disability due to chronic illness or age, while an additional one-third (31.8 per cent) were necessitated

TABLE 4. *Reasons for First Admissions to Public Homes, Distributed by Age, New York State, Exclusive of New York City, 1938* [1]

REASON FOR ADMISSION	TOTAL		DISTRIBUTED BY AGE [2]		
	Number	Per Cent	Under 16 Years	16 to 64 Years	65 Years and Over
Total admissions	5,252	100.0	143	3,125	1,984
Prolonged residence for disability due to chronic illness or age	2,592	49.5	10	962	1,620
Temporary medical care	1,670	31.8	123	1,272	275
Temporary shelter	970	18.4	10	876	84
Not reported	20	0.3	.....	15	5

[1] New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, "Physical Condition of Persons Admitted to County Homes," *Medical Care in New York State, 1939*, Legislative Document (1940) No. 91, p. 184.

[2] Per cent distribution, by age: total, 100.0%; under 16 years, 2.7%; 16 to 64 years, 59.5%; 65 years and over, 37.8%.

[35] The Rhode Island State Department of Social Welfare maintains a file of licensed homes for aged or convalescent persons and existing vacancies which is available to qualified agencies placing clients. Placement service is also made available by the Department to physicians and individuals.

[36] Based on data from *Directory of Institutions for Adults*, New York State Department of Social Welfare, 1943, and revisions for 1944.

[37] State of Illinois, Committee to Investigate Chronic Diseases Among Indigents, *Interim Report to the Sixty-Fourth General Assembly*, June 7, 1945, p. 9.

[38] Maryland Legislative Council, Research Division, *Report on Almshouses in Maryland*, April 1940.

[39] From data on medical and hospital care provided individuals under care of the Nassau County Department of Public Welfare, 1944. Collected by the Health Preparedness Commission in cooperation with the Department. To be published.

because of need for temporary medical care—a total of 81.3 per cent.[40] See Table 4, page 31.

Role of the Public Home

Many of the chronically ill in the State are admitted to public homes either because of lack of alternate facilities for long-term care of those not needing hospitalization, or because the public homes may actually be providing the type of care needed. Whatever the reason, these homes today apparently are much used by such patients. Therefore, the question arises as to whether these institutions should continue this service, as part of a comprehensive program for care of the chronically ill, or whether alternate facilities should be established, leaving to the public homes the population not requiring institutionalization for medical or nursing care reasons.

Today the terms "custodial facility," "medical domiciliary institution" and "county home infirmary" are synonymous in the minds of many, with little differentiation between the role of public home infirmaries and nursing homes, except that one is under public and the other under proprietary auspices. With the advent of more widespread public assistance, the individual dependent on government for food, shelter, fuel and clothing no longer must look to the public home as a source of shelter and board. Consequently, the public home population is changing from one of persons primarily seeking subsistence to one of individuals preferring congregate care and of physically and mentally disabled persons unable to care for themselves outside an institution. The "county home farm" in many localities has gradually become a vestigial remainder or an historic tradition, with the inmates often physically unable to perform farm labor chores. The county home, and of necessity its infirmary, is slowly changing its function, even if not consciously so. Its role is merging with that of the nursing home and, in some upstate communities, it is no longer confining its care to the indigent, but is admitting patients able to pay for service.

The Current Situation

As in the case of nursing homes, the Commission Staff has discussed and has had correspondence with informed State and local persons relative to public homes. These contacts reinforce the general impression that the public homes in upstate New York provide a wide range of quality of care, some having excellent standards, others providing only the most meager and dreary custodial care. In this connection, it should be noted that the public homes of Onondaga and Schenectady Counties and Poughkeepsie and New York Cities were registered by the American Medical Association in 1944 as "related institutions," and those of Delaware, Monroe and Suffolk Counties as hospitals[41]—a mark of medical approval. The Monroe County Home is also approved by the American College of Surgeons.

Recent replies from local commissioners of public welfare in the State indicate that 57 welfare districts lack adequate custodial care facilities and an even greater number suitable nursing and convalescent homes.[42]

A number of persons with whom this subject has been discussed are convinced that: (1) Each public home which plans to admit or continue to house chronically ill persons should, in whole or in part, be converted into a cheerful, homelike nursing home of high quality under public auspices. (2) The converted homes should become community facilities and should admit those able to pay for care, as well as the indigent, especially since future admittees may be recipients of Old Age and Survivors Insurance benefits able to pay for at least part of their care. (3) The care of chronically ill public charges admitted to homes meeting minimum standards should be reimbursed by the State Department of Social Welfare under the same formulae applicable to reimbursement for care outside such institutions. (4) Every effort should be made to assist the public homes to throw off their social stigma and insure their acceptance as medically related institutions, just as State tuberculosis and mental hospitals are regarded. (5) The alcoholic, senile psychotic and cerebral arteriosclerotic cases should not continue to be part of the general population of the average public home, but should be provided with proper care either in special institutions or specifically designated sections of the larger public homes.

These are not new or untried conceptions. The Onondaga and Monroe County Home Infirmaries, and probably others, now admit paying patients. Illinois has translated this concept into practice for, after the recent conversion of some of its county homes into chronic care facilities, eligibility for admission has been extended to include patients able to pay for care, and has attracted such patients.[43] Likewise, in Connecticut,[44] Maryland[45] and New Jersey[46] provision is made, or is imminent, for the admission of paying patients to public homes.

Since more adequate public facilities have been

[40] New York State Temporary Legislative Commission to Formulate a Long Range State Health Program, "Physical Condition of Persons Admitted to County Homes," *Medical Care in New York State, 1939*, Legislative Document (1940) No. 91, p. 184.

[41] American Medical Association, *Journal of the American Medical Association* (Hospital Number), Vol. 127, No. 13, March 31, 1945.

[42] New York State Association of Public Welfare Officials in cooperation with the New York State Health Preparedness Commission, *Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill*, mimeographed 1945. (Reprinted infra as Care of the Chronically Ill: The Local Public Welfare Viewpoint, page 37.)

[43] *Laws of the State of Illinois, Sixty-Fourth General Assembly, 1945*, Senate Bill No. 212 (approved June 13, 1945) and Senate Bill No. 213 (approved June 6, 1945.)

[44] *General Statutes of the State of Connecticut, 1945 Supplement*, Chap. 147, Sec. 611h–615h.

[45] *Annotated Code of Maryland, 1943 Supplement*, Art. 43, Sec. 526–530.

[46] State of New Jersey *Laws of 1940*, Chap. 119 (supplementing the "1924 Poor Law"); *Laws of 1939*, Chap. 263, and *Laws of 1946*, Chap. 175 (supplementing the "1931 County Referendum Law").

made available, Illinois has experienced an increased demand for care. However, the demand has been of such volume that the admission of paying patients has been limited to ensure beds for those indigent needing care. This situation is described by the Director of the Illinois Public Aid Commission, as follows:

> "In all thirteen counties where homes are now approved under the chronic care program, it has been necessary to establish admission quotas as between assistance cases and private pay patients and to discontinue the original plan of accepting patients from outside the respective counties. In all of these counties intake has had to be limited according to beds available and to nursing staff available. As a result, as maximum capacity is approached, the waiting list for private pay patients becomes larger in proportion to assistance cases applying for entrance. Far from becoming a "dumping ground" the volume of applications for care has restricted intake and stimulated efforts to match quality and extent of care to the needs of the individual patients admitted. One county has just reported a disturbingly large waiting list of private-pay patient applications for admission because this limitation of intake is necessary."[47]

Local commissioners of public welfare in New York State, themselves responsible for operating public homes, have expressed the following opinions:

> "It would seem to me, considering the State as a whole, that something should be done in the postwar period to provide suitable and sufficiently large county infirmaries in every county in the State so that the infirmary would be in a position to admit chronic cases which are unable to purchase adequate service and care elsewhere. There are many instances where chronic cases are financially able to pay the cost of their care in a county infirmary, but are financially unable to purchase care from an entirely private source, or unable to make arrangements to receive proper care in hospitals or nursing homes."[48]—From letter of Department of Social Welfare of Wayne County, April 21, 1945, signed by Elmer G. Butts, Commissioner.
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> "There is a great and growing need for providing efficient care for the aged and chronically ill at a reasonable cost, for those ineligible for public assistance are anxious to retain their independence as long as possible with their limited resources. We receive many inquiries from relatives able to pay the amount it costs for care at the County Infirmary, yet who are not financially able to undertake an indefinite obligation of $15 to $25 weekly. County Infirmary care is, of course, unavailable to such private patients. The only answer that occurs to us is a convalescent hospital or institution, partially publicly sponsored and supported, where such cases might be cared for efficiently. This should not be regarded as a public assistance project, any more than a farm subsidy, or public provision for a public health problem. We believe such an institution could give much more satisfactory and efficient care than can private homes, where it is almost impossible to guarantee required standards and conditions and where prohibitive prices for this type of care always prevail."[49]—From letter of Department of Public Welfare of Cortland County, May 7, 1945, signed by Frank W. Chrisman, Commissioner.
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> "We also have a great many calls for patients who are chronically ill and whose means are limited. They can and are willing to pay for their relatives oftentimes, if their current earnings are sufficient to pay the charge at the Infirmary, as they cannot manage on hospital or the regular nursing home rates. I feel, as time goes on, we are going to be confronted more with this type of case, which means that public funds will undoubtedly have to be provided to make facilities available to care for this type of case."[50]—From letter of Department of Welfare of Niagara County, May 4, 1945, signed by Milton E. Switzer, Commissioner.
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> "At the present time we have patients in our Infirmary and have also received many applications from patients in the City who are able to pay their way in the Infirmary. Many patients who have been in the hospital ready to be discharged have applied to our Department for admission to the Infirmary. They have no one to care for them at home as the heads of their families are employed, and they are not able to get anyone to come into the homes to look after the patients. If we had a nursing home, these patients could be cared for in the nursing home and it would relieve the congestion in the Infirmary; or, if our Infirmary were enlarged, and the stigma of the City Home removed, it would, undoubtedly, solve our problem on nursing care."[51]—From letter of Department of Public Welfare of the City of Newburgh, May 2, 1945, signed by T. J. Cannon, Director.

Conclusions

A choice eventually must be made. Shall the public homes serve only as places of congregate care for those who, although physically and mentally able, prefer institutional care? Shall the homes be devoted exclusively to caring for the chronically ill not needing hospitalization? Or shall they care for both types of cases, so often progressively interchangeable, simultaneously? This question is partially answered by a number of concurrent circumstances. The public homes are established, built. They already have a large number of the chronically ill under care. Facilities are needed immediately. Limitations of materials and manpower will probably delay any contemplated extensive construction. Therefore, if the public homes plan to admit or continue to house the chronically ill, it seems logical, economical and sound that, whenever structure and location are suitable, the existing homes or a portion of each should be converted to provide medical domiciliary care of high quality under public auspices. If they are thus converted, they would be community facilities, not solely institutions for the indigent, and should be made available to all the population, regardless of economic status. As in the case of other community medically related facilities, patients able to pay for care should do so, with the local departments of public welfare paying for the medically indigent.

In suggesting means of transforming the public homes into suitable institutions because they plan to care for those chronically ill not requiring hospitalization, it is not necessary to evaluate the homes as they are today. But it does seem important to indicate the major factors inherent in effecting their conversion into adequate facilities. Under existing legislation

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[47] From letter of Mr. Raymond M. Hilliard, Director, Illinois Public Aid Commission, to the New York State Health Preparedness Commission, December 4, 1946.

[48] New York State Association of Public Welfare Officials in cooperation with the New York State Health Preparedness Commission, *Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill*, mimeographed 1945. (Reprinted infra as Care of the Chronically Ill, The Local Public Welfare Viewpoint, page 44.)

[49] *Ibid.*, page 45.

[50] *Ibid.*, page 43.

[51] *Ibid.*, page 43.

there are three principal avenues of control: (1) the State Department of Social Welfare now is responsible for approving new construction, expansion and material remodeling of such homes;[52] (2) the Department now has the power to inspect and make recommendations relative to their operation;[53] and (3) the New York State Postwar Public Works Planning Commission has the power to approve or disapprove applications for State capital funds for such facilities. Current trends indicate the possibility of two other means of control in the near future: (1) If the State should reimburse for care of the medically indigent in public homes, it could prescribe the conditions under which reimbursed care should be provided. (2) If comprehensive State licensure of all institutions caring for ill persons were initiated, the requirements thereunder for institutions caring for the chronically ill would be applicable to the public homes accepting such patients.

Moreover, it seems timely now to consider the trend that our capital expansion should take. Fourteen counties are currently planning new construction, expansion or material remodeling of their respective public homes. The aggregate estimated construction cost for the projects in 10 of these counties is $2,677,730. For the slightly different 10 counties whose eventual planned capacities are known, there will be a rise from 1,497 beds to 2,038 beds, an increase of 36 per cent. Most of these projects have already been approved by the State Department of Social Welfare and by the State Postwar Public Works Planning Commission. **See Table 5.**

[52] *Social Welfare Law of New York State*, Annotated, Sec. 202.
[53] *Ibid.*, Sec. 201, 203.

TABLE 5. *Counties Submitting Plans for New Construction or Material Remodeling of Their Public Homes to the New York State Department of Social Welfare, As of October 24, 1946* [1]

COUNTY	Description of Project	Total Capacity of Home (Inc. Infirmary)		Approval of Preliminary Plans		Estimated Construction Cost
		Present	Planned	By State Dept. of Social Welfare	By State Postwar Public Works Planning Commission	
Broome	Renovation of men's building, recreation room. New serving pantry	320	350	.....	.....	No report
Cattaraugus	New infirmary, women's building, employees' wing, residence for commissioner, residence for farmer	157	300	x	x	$326,771
Chemung	New men's building. New central heating plant under consideration	170	190	x	x	$300,000
Chenango	New men's building. New central heating plant under consideration	125	165	x	.....	No report
Cortland	Complete new plant	85	NR	Pending	x	$292,900
Essex	Considering additions and alterations	62	130	Tentative	x	$125,000
Livingston	Complete new plant	90	156	x	x	$378,956
Niagara	New infirmary wing. New central heating plant under consideration	350	419	Tentative	x	$231,132
Otsego	In process of planning extensive additions	125	NR	.....	.....	No report
Sullivan	Complete new plant at new site	60	100	Tentative	x	$308,660
Tompkins	New infirmary at site apart from county home.	52	NR	Pending	x	$185,324
Ulster	In process of planning additions	100	140	.....	x	$75,000
Washington	Small addition	145	NR	x	.....	No report
Wyoming	Complete new plant	63	88	x	x	$148,000

NR —" no report "

[1] Data adapted from information supplied the Health Preparedness Commission by the New York State Department of Social Welfare in a letter of October 24, 1946; *except* that information on estimated construction costs are those reported in *Approved State and Municipal Projects*, New York State Postwar Public Works Planning Commission, September 1, 1946.

Regulation relative to such homes desiring conversion might be made applicable (1) at the time of construction or remodeling and (2) during the period of operation. Future construction should be realistically conceived by meeting current and potential needs rather than by following any traditional pattern. State agencies exercising controls over new construction or remodeling could formulate criteria prerequisite to approval, including proof of the ability of the sponsoring agency to operate the contemplated facility properly. Such standards might include requirements of a medical care nature, of which the following are illustrative:

1. Approval should be based upon the results of a survey, for each community contemplating construction, of the local medical and medically related facilities, their capacities and relationship to each other.
2. Consideration should be given to the use of existing, little used, yet appropriate, capital structures in lieu of new construction. (For example: The conversion of a wing of a general hospital having low occupancy. The conversion of one or all of several well-constructed units of a multi-unit local tuberculosis hospital having a decreasing patient population).
3. Consideration should be given to the question as to whether or not the county (or city) which will operate the institution is sufficiently populous to justify the capital expenditure. If not sufficiently populous, service might be bought from an adjacent county or city.
4. A careful analysis should be made as to whether or not the future program of the institution should incorporate a farm operation. (Today fewer and fewer inmates are physically capable of performing agricultural labor chores.)
5. Whenever possible the institution should be located close to the greatest concentration of population of the county, preferably near an approved general hospital. (Location is a factor in the availability of personnel, accessibility to the services of a general hospital and the willingness of patients to patronize the facility.)
6. The structure, or a part thereof, should be conceived as an allied medical institution and should be planned functionally to serve this purpose efficiently and economically.
7. The institution should be so planned and placed on the terrain as to allow for future structural expansion by the addition of wings or additional floors in conformity with the basic architectural pattern.
8. Any plan submitted for approval should provide space for recreational, occupational therapy and rehabilitative activities of the inmates, i.e., assembly room (auditorium), chapel, workshops, etc.
9. The immediate contemplated capacity of the structure should take into consideration (a) the population of its predecessor, (b) the waiting list, (c) the desirability of admitting individuals now inappropriately under care in proprietary nursing homes, general hospitals or their own homes and (d) the estimated increase in numbers in the near future of age groups and types of medical cases eligible for care.
10. Approval of the plans submitted should be contingent upon the willingness of the sponsoring authorities to admit full-pay and part-pay patients who fulfill the economic, social and medical conditions of eligibility.
11. The sponsoring authorities should present a statement of the anticipated needed numbers and qualifications of various types of personnel required to operate the institution; and the approving authorities should determine whether the professional and non-professional personnel complement and their qualifications are such as to provide the high quality of service required.
12. The sponsoring authorities should present a detailed budget on anticipated annual gross and net operating costs and per diem costs per inmate, preferably by type of service to be provided, i.e., nursing care, medical domiciliary care, shelter care, etc.

Standards of operation might well embrace those relative to safety, fire protection, sanitation, facilities, equipment, accommodations, furnishings, administration, personnel, admission and discharge, nursing service, medical service, records and reports. Since the diversity of competence required to evaluate the institutions on the basis of these criteria exceeds that of any one individual, with rare exceptions, it is advisable that the determinations be made by an experienced and qualified "team" of individuals who, as a group, possess these abilities.

The following exemplify a few of the standards, of a medical nature, which might profitably be required to insure proper operation:

1. The institution, or at least a part thereof, should be regarded as an allied medical institution, occupying the same place in the community for the type of service it provides as an approved general hospital enjoys for its appropriate type of service.
2. It should be eligible for registration as at least a "related institution" by the American Medical Association, i.e., conforming to the requirements for such registration.
3. The individuality of patients should be preserved by offering (a) either single rooms or ward units not exceeding a capacity of four, (b) a variation among the rooms as to color of paint on the walls, and (c) dining tables of small capacities, not exceeding six.
4. The following types of patients should be eligible for care, regardless of economic status:
   (a) *Convalescent patients* for whom an organized, planned, institutional regime is medically indicated and those requiring less planned care, but whose homes are unable to provide the type care needed.
   (b) *Bedridden cases* requiring medical domiciliary care, but not hospitalization, and for whom this type of care cannot be provided in the patient's own home.
   (c) *Ambulant and semi-ambulant cases* not requiring hospitalization who cannot be suitably placed in supervised boarding homes and whose own homes are undesirable.
5. The institution should admit such full-pay and part-pay patients, in addition to the medically indigent, as may request admission.
6. The medical staff of the institution should be chosen in the same manner which is customary among the approved local general hospitals, i.e., open service, closed service, rotating service, etc.
7. The medical staff of the institution should be organized into a medical committee under a salaried medical administrator serving either on a full-time or part-time basis.
8. No institution should provide the active type of medical service which is commonly regarded as the province of the general hospital, but each should formulate a working agreement with one or more of the local registered general hospitals,[54] and preferably with one also approved by the American College of Surgeons.

[54]Registered by the American Medical Association as a hospital.

9. The decision to transfer a patient from the institution to a general hospital, or vice versa, should be made only on recommendation of a physician.
10. The ratio of registered and practical nurses and attendants to the patient population should conform to a specified minimum.
11. Each institution should have an organized program of rehabilitation and occupational therapy so graded that the patient can progress from one type of activity to another.
12. Each institution should review, at stated intervals, and on a medical-social casework basis, the potentiality for discharge of each patient or his transfer to an institution providing a type of care more appropriate to his condition.

VOLUNTARY HOMES FOR THE AGED

As in the case of public homes, the Subcommittee on Adult Institutional Care of the Special Committee on Social Welfare and Relief of the New York State Joint Legislative Committee on Interstate Cooperation will undoubtedly report detailed data, conclusions and recommendations on voluntary homes for the aged. Mention thereof is made here only to call the attention of the reader to the fact that these institutions now are playing an increasingly important role in the care of the chronically ill between hospital and home. Furthermore, their contribution might be augmented, to the mutual benefit of themselves and the community.

The New York State Department of Social Welfare exercise supervisory responsibility relative to 200 voluntary homes for the aged whose aggregate capacities in upstate New York approximate those of the public homes for that area.[55] This indicates the extent of such facilities, many of which number chronically ill persons among their populations.

Frequently established and maintained by fraternal, church or nationality organizations, homes for the aged generally have well-known and publicized admission policies. Up to now many have restricted application to members of the sponsoring organization and, traditionally, many have accepted for care only persons in good health at the time of admission. This latter prohibition has not been wholly effective as persons in "good health" are likely to become ill shortly after admission, while others, rejected for relatively mild physical defects, remain ambulant and active for years. The advent of the Old Age Assistance and Old Age and Survivors Insurance programs have made possible the subsistence of many old persons outside institutions, thereby influencing the size of the institutional populations and waiting lists.

Since many of these homes accept responsibility for guests who become ill following admission, they should be encouraged and assisted to provide proper, adequate and continuous medical and nursing service for such patients. Also, a liberalized admission policy might tend to stabilize the financial condition of some homes for the aged for two reasons: (1) the homes, now often populated by persons admitted on a life basis,[56] might be better able to attract recipients of public assistance; and (2) might similarly attract the beneficiaries of Old Age and Survivors Insurance benefits. Therefore, and especially in the light of community needs, these institutions might be encouraged to adapt a greater part of their facilities and programs to the care of persons known to be chronically ill at the time of admission. If the physical structure of the homes could be converted, their admission policies liberalized and their programs modified to meet this need, the resulting service to the respective communities would be enhanced; and chronically ill persons of similar religious, fraternal or nationality backgrounds could more readily and happily be placed in institutions of their choice.

CONCLUSIONS

Nursing homes, supervised boarding homes, county and city public homes and voluntary homes for the aged are adaptable, potential resources for providing care between hospital and home to the chronically ill who, although not requiring hospitalization, cannot receive suitable long-term or convalescent care in their own homes. If properly conceived (or converted), staffed and operated, these three types of institutions could provide an invaluable, psychologically sound, much needed service more economically than can purely medical institutions; while the supervised boarding home of high quality could supplement the medical domiciliary type of service. The demand for service is so great that a place exists for all these facilities, in addition to others; but their continued existence may well depend on their ability to adapt to community needs and to conform to minimum standards of performance.

Although some of these facilities provide adequate care today, others must be altered physically and encouraged to provide a better quality of service. To this end the following suggestions, previously discussed in more detail, are reiterated for consideration:

1. All facilities of the nursing home type should be made subject to State regulation, preferably through inclusion under a comprehensive licensure system covering all institutions caring for ill persons. However, if such licensure is not advisable or attainable at an early date, registration of nursing homes should be established immediately.
2. The State Department of Social Welfare, in cooperation with local departments of public welfare, might assume leadership in formulating standards for those supervised boarding homes which accommodate public charges; and might ultimately make available to the non-indigent a register of such approved homes.
3. Each public home which plans to accept chronically ill persons for care might be converted, in whole or in part, into an institution capable of adequately caring for those chronically ill who, although not needing hospitalization, cannot be cared for properly in their own homes or in supervised boarding homes. It

[55] New York State Department of Social Welfare, *Social Welfare Services in New York State*, Albany, May 1946, p. 3.

[56] The practice whereby a lump sum is paid upon admission to defray the cost of care of the admittee for life. Since such fees are often admittedly below the aggregate cost of care per individual, the differential must be met by philanthropic funds, a diminishing source of income.

should become a general community facility, admitting those able to pay for care as well as the indigent; and should be developed as an integral part of the gamut of local medical services. In addition, State reimbursement should be made available for the care of chronically ill public charges placed in public homes meeting minimum prescribed standards.

The standards of construction and operation of such converted public homes could be achieved by (1) the enforcement of criteria of construction prerequisite to State approval for building new facilities, or remodeling existing structures; and (2) the establishment and application of State regulations relative to standards of maintenance and operation.

4. Voluntary homes for the aged should be encouraged to liberalize their admission policies and to adapt a greater part of their facilities and programs to the proper care of chronically ill persons.

CARE OF THE CHRONICALLY ILL: THE LOCAL PUBLIC WELFARE VIEWPOINT (1945)*

FOREWORD

The steadily rising proportion of the aged in the general population, which has followed the extension of the span of life by advances in medical science, is inevitably increasing the number of persons with chronic disease. Consequently, the present inadequacy of facilities and services for the diagnosis, treatment and rehabilitation of the chronically ill, in either institutions or in their own homes, presents a pressing problem which must be met.

The New York State Health Preparedness Commission, which is working on plans to provide this needed care, has recognized the value of the experience and opinions of public welfare officials dealing directly with this problem as it relates to the recipients of public assistance and the medically indigent. Therefore, the Commission asked the New York State Association of Public Welfare Officials to secure an informal expression of opinion from the county and city commissioners of public welfare as to the extent of the problem, the adequacy of existing facilities and the means by which service might be improved.

Because the replies included such significant and interesting data, they were summarized in a preliminary report for submission to the local commissioners who later verified, in writing, the facts and statements presented relative to their respective territories and gave permission for their publication. At the same time several commissioners forwarded supplementary information. Although not included herein, these additional data strongly confirm the general opinions and trends presented in the following material.

HIGHLIGHTS

Although the formulation of a plan for the care of the chronically ill by the New York State Health Preparedness Commission will apply to patients in all economic strata, information relative to patients in the State who are chronically ill and also medically indigent is significant in such planning.[1] It is generally accepted that three-quarters or more of all chronically ill persons are either medically indigent when the chronicity is first noted or become so during the ensuing period of illness. Therefore, any facts concerning these patients apply to a majority of the chronically ill population. Data relative to them are available from the county and city departments of public welfare who pay for the medical and hospital care of medically indigent citizens.

In April, 1945, a letter was sent to the 106 local commissioners of public welfare (57 county and 49 city commissioners) requesting their opinions on the adequacy of existing facilities and services for the care of the medically indigent chronically ill and inviting their suggestions for improving services to these patients.[2] As shown in Figure 2, page 38, replies were received from 43 counties and 39 cities in upstate New York and from New York City, over three-quarters of the addressees.[3]

By using the letter rather than a questionnaire to conduct the inquiry, the replies were in the words of the respective commissioners. Each addressee was free to reply in detail and was not confined to the limitations of a formal questionnaire. Consequently, in tabulating the returns some terms used seem repetitious, for individuals, often meaning the same thing, do not express themselves in identical terms.

The major findings, as indicated by the replies received, are as follows:

1. According to the commissioners, the cases giving the most difficulty to the local departments are: (a) mental cases which are too disturbed to be properly cared for in nursing homes and most public infirmaries, yet are psychiatrically ineligible for admission

*This material, secured by the New York State Association of Public Welfare Officials in cooperation with New York State Health Preparedness Commission, was previously published in mimeographed form by the Commission as "Suggestions of Local Commissioners of Public Welfare on Planning for the Care of the Chronically Ill," the Foreword bearing the signature of Miss Elsie M. Bond, Secretary, New York State Association of Public Welfare Officials.

[1] "Medically indigent" is herein used to describe not only recipients of public assistance for food, shelter, clothing, etc., who also receive medical care at public expense, but also those persons who, able to provide the routine necessities of maintenance for themselves, become public charges for medical and hospital care.

[2] See copy of letter, page 49, written to the commissioners by Miss Elsie M. Bond, Secretary of the New York State Association of Public Welfare Officials and Secretary of the New York State Health Preparedness Commission.

[3] Replies were not received from the following:

Counties (14): Chemung, Fulton, Herkimer, Jefferson, Ontario, Otsego, Rensselaer, Rockland, St. Lawrence, Schoharie, Seneca, Tioga, Ulster, Yates.

Cities (9): Hudson, Kingston, Little Falls, Mechanicville, North Tonawanda, Norwich, Ogdensburg, Peekskill, Saratoga Springs.

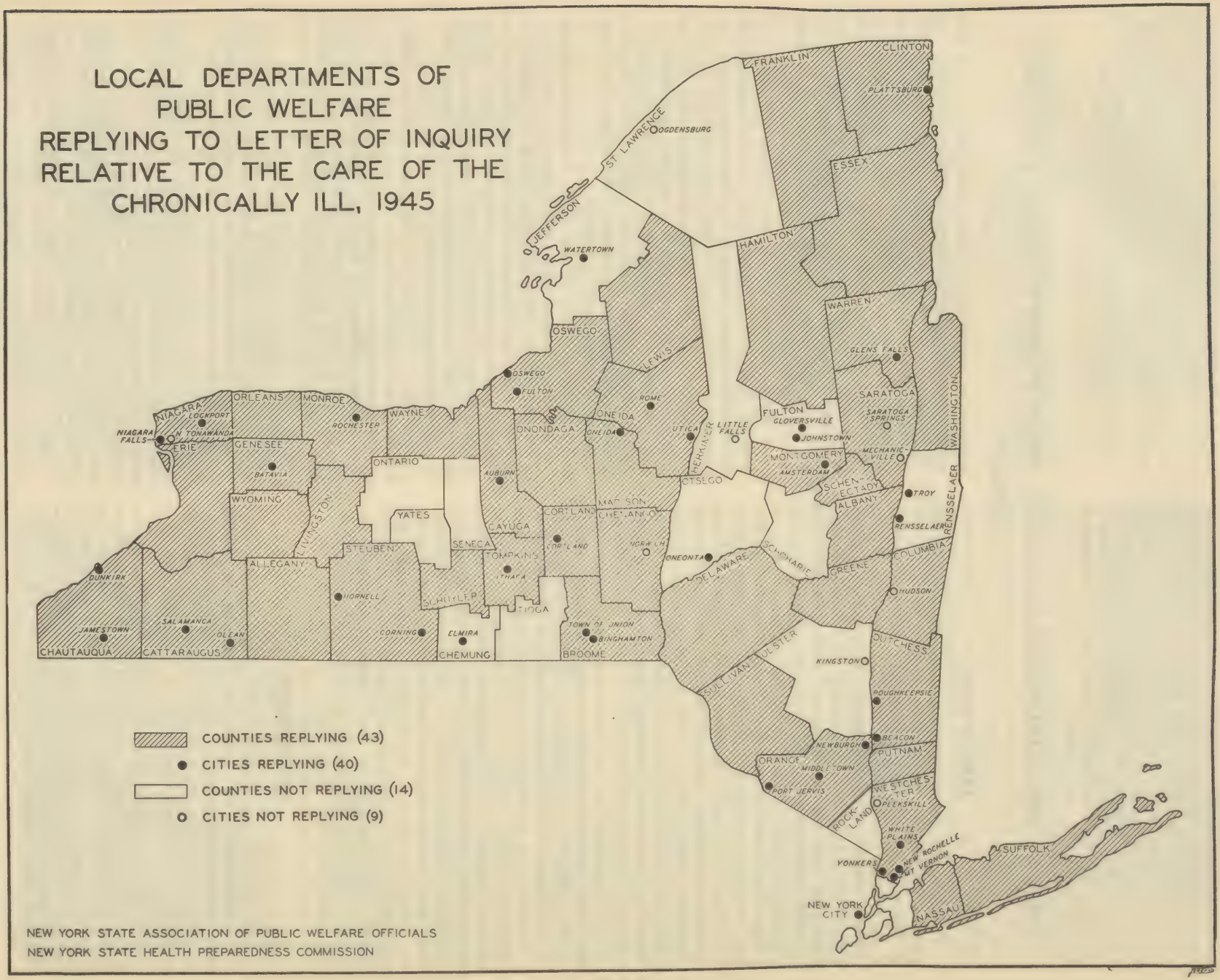
LOCAL DEPARTMENTS OF PUBLIC WELFARE REPLYING TO LETTER OF INQUIRY RELATIVE TO THE CARE OF THE CHRONICALLY ILL, 1945
COUNTIES REPLYING (43)
CITIES REPLYING (40)
COUNTIES NOT REPLYING (14)
CITIES NOT REPLYING (9)
NEW YORK STATE ASSOCIATION OF PUBLIC WELFARE OFFICIALS
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION
CLINTON
FRANKLIN
ST LAWRENCE
JEFFERSON
LEWIS
ESSEX
HAMILTON
WARREN
WASHINGTON
SARATOGA
FULTON
MONTGOMERY
SCHENECTADY
RENSSELAER
ALBANY
TROY
SCHOHARIE
OTSEGO
DELAWARE
COLUMBIA
GREENE
DUTCHESS
ULSTER
SULLIVAN
ORANGE
PUTNAM
ROCKLAND
WESTCHESTER
SUFFOLK
NASSAU
NEW YORK CITY
OSWEGO
ONONDAGA
ONEIDA
MADISON
CORTLAND
CAYUGA
SENECA
TOMPKINS
TIOGA
BROOME
CHENANGO
CHEMUNG
SCHUYLER
STEUBEN
ALLEGANY
WYOMING
LIVINGSTON
ONTARIO
YATES
GENESEE
ORLEANS
MONROE
WAYNE
NIAGARA
ERIE
CHAUTAUQUA
CATTARAUGUS
WATERTOWN
OGDENSBURG
PLATTSBURG
GLENS FALLS
SARATOGA SPRINGS
JOHNSTOWN
GLOVERSVILLE
AMSTERDAM
MECHANICVILLE
HUDSON
KINGSTON
POUGHKEEPSIE
BEACON
NEWBURGH
MIDDLETOWN
PORT JERVIS
PEEKSKILL
WHITE PLAINS
NEW ROCHELLE
MT VERNON
YONKERS
UTICA
ROME
ONEIDA
LITTLE FALLS
OSWEGO
FULTON
AUBURN
CORTLAND
ITHACA
ONEONTA
NORWICH
BINGHAMTON
TOWN OF UNION
ELMIRA
CORNING
HORNELL
DUNKIRK
JAMESTOWN
SALAMANCA
OLEAN
NIAGARA FALLS
LOCKPORT
N TONAWANDA
BATAVIA
ROCHESTER

FIGURE 2

to State mental hospitals under present admission requirements; (b) senile patients, many of whom are deteriorating; and (c) cases requiring long-term nursing care but not hospitalization.

2. The welfare departments reported that the care of the chronically ill is a problem primarily because of a lack of local custodial institutions, proper nursing homes, hospital facilities for intensive medical care and, to a lesser extent, diagnostic facilities.
3. Whenever a local department tends to refer its medically indigent cases, including the chronically ill, out of its immediate territory for diagnosis and treatment not locally available, it indicates a desire to provide a good quality of medical care. It is therefore gratifying that four of every five departments follow this practice and that, with a few exceptions, the rest are those with medical teaching centers in their midst. The centers within the State which are most frequently used are Albany, Buffalo, New York City, Rochester and Syracuse, all recognized medical centers. The counties along the southern tier refer cases to Sayre, Pa., and those in the northeastern section to Montreal. In addition, a number of counties, regardless of proximity, send terminal cancer cases to Rosary Hill at Hawthorne, Westchester County.

   In isolated instances, difficult cases requiring the services of particular highly regarded specialists, have been sent to the University of Pennsylvania Hospital in Philadelphia, Crile Clinic in Cleveland, Mayo Clinic in Rochester, Minn., Lahey Clinic and Massachusetts General Hospital in Boston and Johns Hopkins Hospital in Baltimore.
4. The most frequent suggestions made for improving the present service to the chronically ill were the erection of new or the improvement of existing public infirmaries, the expansion of hospital facilities and the encouragement of more adequate nursing homes. Some welfare departments noted that the public home infirmary of the future should be devoid of the stigma now often associated with it, should admit paying patients and should provide service superior to that of the average proprietary nursing home of today. Others, favoring the further development and improvement of nursing homes, felt that these offered a more homelike and congenial setting for long-term care.
5. Relative to State assistance, one-third of the welfare departments advocated State reimbursement for overall care provided locally to the chronically ill, regardless of place of care. An additional one-quarter favored reimbursement for public infirmary care and a lesser number assistance with hospitalization. Suggestions were also made for State financial participation in the capital expansion of local medical facilities and the establishment of such State operations as regional hospitals, diagnostic and consultative services and institutions for borderline mental cases.
6. Over a third of the departments indicated that their respective communities are formulating or considering plans for improving local services. Some are interested in hospital and clinic expansions, others in developing improved nursing home care. But the majority were interested in improving their public infirmaries. In this connection, it should be noted that, as of December 26, 1945, the State Postwar Public Works Planning Commission had approved, for planning purposes only, the plans of eight counties for infirmary construction and/or improvement at an aggregate estimated construction cost of $1,745,588. No doubt other counties have similar plans awaiting approval by the Commission or are promoting them as entirely local projects not subject to action by the Commission. This impetus indicates a trend, a concern for the care of infirmary patients and an acceptance of responsibility by local communities for improved service.

THE PROBLEM

The promptness and detail of the replies from the commissioners indicate their recognition of and interest in the problem of chronic illness. They emphasize the urgency of solving the problem. They voice, often by indirection, their inability to greatly ameliorate the situation solely by local initiative and financing. They are groping for a solution, often without a full conception of the need for a high quality of service and early diagnosis. They frequently emphasize the role of the county home infirmary. One cannot be sure whether their concern is due to the possible large proportion of chronically ill in the local case loads, or to the fact that caring for the chronically ill consumes a disproportionate amount of administrative effort because of limited facilities and services for the care of such patients.

The types of cases giving the local departments of public welfare the most difficulty are: (1) the mental cases which are too disturbed to be properly cared for in nursing homes and in the average public infirmary, yet are not committable to state mental hospitals under current admission requirements; (2) the deteriorating seniles; and (3) cases requiring long-term nursing care but not hospitalization. The replies described many of these cases as end products requiring institutionalization and indicated that probably only a few might be reclaimed for socially productive activity by prompt medical care of high quality. A number of the comments on the mentally ill patients included the suggestion that preventive mental hygiene services are needed and should be provided as a State responsibility.

The following excerpts from the letters are illustrative of the comments on the senile and mentally ill persons under care of local public welfare departments.

> "The type of case which gives the most difficulty is that of the chronically ill, aged person with personality disintegration and senile conduct who does not need care in a state hospital, yet is a very difficult patient in a nursing home. Because of the crowded conditions and lack of adequate staff, many of the private nursing homes absolutely refuse to give this type of patient the kind of care and understanding patience which his condition demands."—From letter of Department of Welfare of the City of Binghamton, April 19, 1945, signed by James H. Robinson, Commissioner.
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> "When a person gets to such a mental state that he needs constant supervision we have to resort to the state hospitals, something we dislike to do for two reasons: (1) most of the cases are senile and not really mental cases and (2) the state hospitals are overcrowded now and each senile, troublesome old person we place in a state hospital deprives someone of care who might otherwise be helped.
>
> "The cases giving us the most difficulty are not so much those who are bed-ridden as those who have chronic ailments coupled with a tendency toward senility. They are not sufficiently ill to be placed in the convalescent home, such as we have at present, and yet it is really not safe to leave them in their own homes. They plan very unwisely and constant social supervision is needed to keep them on anything like an even keel."—From letter of Department of Social Welfare of Madison County, April 10, 1945, signed by Mrs. Geraldine Wheeler, Commissioner.
>
> "In the case of county home infirmaries: What is the

definition used to determine the responsibility of the county home and the State Department of Mental Hygiene? Since the county home has no power of restraint or confinement and as the Department of Mental Hygiene, whose hospitals are already overcrowded, is reluctant to accept senile cases, where should they be cared for? To what extent should county homes inaugurate facilities for such care? Should there be a change in legislation empowering county homes to confine or restrict seniles? Our experience has shown that there is a diversity of opinion in the decisions of expert examiners as to the degree of mental illness. This has caused a problem for both the county homes and the Department of Mental Hygiene."—From letter of Department of Public Welfare of Chautauqua County, May 1, 1945, signed by F. A. Waterman, Commissioner.

"Our problems seem to have centered largely in the care of senile psychotics or at least those who are rather badly deteriorated, mentally as well as physically. The general type of nursing home care is not really what they need, but rather a more specialized custodial type of care in which they are not combined with the chronic sick who do need a more individualized type of service. Those who need and are capable of benefitting from more individualized care in a more normal home environment are handicapped in their treatment by the presence of the senile or borderline dementia cases who are frequently obstreperous and difficult to handle."—From letter of Department of Public Welfare of Westchester County, May 29, 1945, signed by Ruth Taylor, Commissioner.

TABLE 6. *Types of Cases Reported as Giving the Most Difficulty to Local Departments of Public Welfare, 1945* [1]

TYPE OF CASE	NUMBER OF WELFARE DEPARTMENTS REPORTING		
	Total	County	City
Mental illness			
Non-committable	18	11	7
Neurotic, personality problem	9	5	4
Senility	21	14	7
Long-term nursing care required	17	9	8
Cancer	9	7	2
Cardiovascular	8	3	5
Arthritic	6	3	3
Patients unable to care for selves who insist on remaining in own homes	5	3	2
Chronic alcoholic	4	1	3
Cases requiring custodial care	3	..	3
Diabetic	3	1	2
Bone fractures	1	..	1
Borderline institutional cases	1	1	..
Drug addiction	1	..	1
Homebound chronically ill patients	1	..	1
Neurological	1	1	..
Patients with frequent exacerbations who are rejected for care by local Department of Hospitals	1	..	1
Patients requiring psychiatric treatment	1	..	1
Physically handicapped patients requiring care relative to personal hygiene	1	..	1
Syphilitic	1	1	..
Tuberculous (long-term)	1	..	1

[1] Includes replies from 39 counties and 31 cities, some of which cited more than one type of case.

"While the staff of the Department feels that it has many problems due to fractures among the aged, I feel these are due more to the psychological factors than to the purely medical."—From letter of Department of Public Welfare of the City of Jamestown, April 21, 1945, signed by Carroll M. Hall, Commissioner.

In addition to the problems of mental illness, senility and long-term nursing care, difficulties were noted in providing proper care for cancer, cardiovascular, arthritic, diabetic and chronic alcoholic patients and, to a lesser extent, to other diagnostic groups. See Table 6, page 40, and Table 12, page 50.

AVAILABILITY OF FACILITIES AND SERVICES

In giving their opinions as to the availability of facilities and services, most of the commissioners noted lacks only when resources were not available within the geographical area within which they are accustomed to go for medical care. In these days of improved transportation many commissioners regard as their local area the relatively close surrounding territory, disregarding county lines. This commendable desire to use services on a regional basis is expressed in the reply of the Commissioner of Public Welfare of Allegany County: "Part of our difficulties are due to complete absence of public transportation facilities from many of our villages and very inadequate transportation facilities from our largest centers, which would enable us to send patients to Rochester or Buffalo. It takes from five to twelve hours to get a person from Allegany County to either Buffalo or Rochester on public transportation facilities when they are available."[4]

Even though a local department of public welfare may be mindful of the need for prompt and competent diagnosis and treatment and sends patients to neighboring communities for such service, it must rely on local facilities for care following the return of the patient to his own home. Therefore, although the use of specialized facilities and services somewhat distant may be advisable, it seems logical that public officials should be able to rely upon local resources for following up a majority of the medical recommendations made. Unfortunately, this is not always the case, as shown by the statement of the Commissioner of Public Welfare of Schuyler County: "These cases (patients sent out of the territory for specialized medical service) are returned to the family physician with recommendations which in most cases cannot be carried out because of lack of facilities."[5]

[4] From letter of Department of Public Welfare of Allegany County, April 19, 1945, signed by W. C. Kelly, Commissioner.

[5] From letter of Department of Public Welfare of Schuyler County, April 11, 1945, signed by Stewart J. Coats, Commissioner.

TABLE 7. *Availability of Facilities and Services as Reported by Local Departments of Public Welfare, 1945*

FACILITY OR SERVICE	TOTAL				COUNTIES				CITIES			
	Total	Lack	No Lack	NR	Total	Lack	No Lack	NR	Total	Lack	No Lack	NR
Diagnostic services	83	15	66	2	43	11	31	1	40	4	35	1
Hospital facilities for intensive medical care	83	44	33	6	43	26	14	3	40	18	19	3
Adequate nursing and convalescent homes	83	67	15	1	43	37	5	1	40	30	10	...
Adequate facilities for custodial care	83	57	16	10	43	33	6	4	40	24	10	6

"NR" indicates no reply.

The localities reported as lacking adequate hospital, nursing home and custodial facilities are, in general, the same areas which persons on the State level, cognizant of local situations, regard as needing either expanded or better quality facilities. However, the same correlation does not pertain to diagnostic services.

The returns indicate that the greatest lack is in the number and quality of nursing homes and in the capacity of the custodial care facilities, an appreciable inadequacy in hospital resources and a relatively negligible need in diagnostic services. This latter fact seems to indicate that a number of the commissioners are more aware of inadequacies when they can be measured in terms of beds in hospitals, nursing homes and infirmaries than when measured by quality, as in the case of diagnostic services. See Table 7, page 41, and Table 13, page 52.

Diagnostic Services

The comparatively small reported need for diagnostic services in upstate New York is contrary to the general impression of individuals, both official and non-official, viewing the situation from the State level. This disparity may be due to an erroneous evaluation by the latter persons or to some local commissioners emphasizing the availability of a physician to diagnose, regardless of his ability, rather than the availability of competent, experienced, specialized diagnostic personnel and facilities. Or it may be that the non-relief, medically indigent often do not apply for public assistance "for medical care only" until hospitalization or other institutionalization is no longer avoidable, and diagnosis therefore becomes a part of the hospital admission procedure rather than a preventive service which might have precluded hospitalization. Thus the commissioners, having an understandable pride in their local medical institutions, consider the diagnosis made at the time of admission as adequate and report no lack of diagnostic services.

Conversely, other commissioners noted the need for competent, early diagnosis as a preventive measure and as a tool in proper treatment. This conception is evidenced by the following statement made by the Commissioner of Livingston County: "It does not seem that an actual lack of diagnostic services exists, but rather a failure to use such services early enough."[6]

New York City reports a lack of diagnostic services for the older age group of the chronically ill and states that the out-patient departments of hospitals, too crowded in normal times, are now faced with an acute problem due to the shortage of medical personnel. In this connection it should be observed that, whereas the public welfare departments in upstate New York pay fees to private practitioners for office and home visits of the medically indigent, New York City tends to rely upon the out-patient services of public and voluntary hospitals at no charge to the City Department of Public Welfare.

Hospital Facilities

Data recently secured from the general hospitals in upstate New York by the New York State Health Preparedness Commission emphasize the lack of hospital beds to care for even the short-stay acutely ill patients, much less the longer term chronically ill. Many expressed a reluctance to admit the latter under present conditions. The returns from the commissioners reiterate these facts, two-thirds of the upstate county and one-half of the city commissioners commenting on the lack of hospital facilities for intensive medical care of the chronically ill. This situation is described by the Commissioner of Wyoming County as follows: "We find that hospital facilities for chronic cases are definitely limited due to overcrowding. There is a reluctance on the part of physicians to hospitalize chronic cases on this account. We do not have an adequate supply of nursing and convalescent homes. As for adequate facilities for chronic cases needing custodial care, we literally have no such facilities. Our County Home is neither adequately staffed nor equipped for that type of service."[7] The extent to which the demand for hospital beds will continue is uncertain. However, since this demand is partially due to more general acceptance of hospital

[6]From letter of Department of Public Welfare of Livingston County, May 1, 1945, signed by J. Donald Root, Commissioner.

[7]From letter of Department of Public Welfare of Wyoming County, April 16, 1945, signed by Edgar E. Wheeler, Commissioner.

care by the public and to the impetus of hospitalization insurance plans, it is probable that the demand for beds will not drop to the prewar level.

An analogous situation exists in New York City whose Commissioner of Public Welfare comments: "Hospital beds are in great demand by the acutely ill and, since so few facilities have been set up for the study of the chronically ill patients, the interns in the wards are more eager to treat acutely ill patients as they believe this is the experience they most need and, therefore, are less interested in the older chronic patients. Therefore, there is a tendency to discharge the chronically ill person immediately the acute exacerbation has subsided and the responsibility for providing care for such cases becomes that of the Department of Welfare due to lack of facilities for care of this type of patient in the hospitals."[8]

Nursing and Convalescent Homes

Nursing home type of care, by whatever institution provided, is most necessary in any well rounded program for care of the chronically ill. It is used to relieve the demand for general hospital beds by patients not requiring intensive medical care, yet needing more than custodial service. A lack of nursing homes, the crowded conditions of the existing ones, the demand for beds and the inadequacy of many existing nursing homes was reported by over three-fourths of the commissioners, most of whom regarded nursing home service as a supplement to general hospital care. Although few differentiated between the role of the nursing home and that of the county home infirmary, practically all realize that the nursing home is an important, yet often an inadequate, resource of the local departments of public welfare in making plans for the chronically ill.

Many of the upstate commissioners who noted the poor quality of the homes expressed the opinion that the State should take steps to raise standards. Some thought that nursing homes of high quality under public auspices are needed. Many are aware that some proprietary nursing homes are used not because they are satisfactory, but because they are the only resources available at rates which the departments of public welfare can pay. In New York City the number of proprietary nursing homes is regarded as insufficient to meet the demand, the rates are considered too high and control of standards not adequate.

The pressure upon local departments to find nursing home beds, the inability of some departments to meet current rates and the poor quality of some homes are illustrated by the following comments:

> "Due to the acute conditions in hospitals, patients are discharged before they are able to care for themselves. Because of lack of nursing home facilities this condition is becoming serious."—From letter of Department of Public Welfare of the City of Troy, April 27, 1945, signed by W. Frank Leversee, Commissioner.
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> "Our so-called nursing and convalescent homes are inadequate. They are understaffed and not properly equipped to provide extensive bedside care for chronic cases. They are willing to accept the infirm and homeless who require a minimum of care but those admitted are mostly ambulatory. In this sense they are but glorified boarding homes."—From letter of Department of Public Welfare of Montgomery County, May 3, 1945, signed by Roland Hoffman, Commissioner.
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> "In the City of Buffalo and the County of Erie, we have encountered considerable difficulty in finding nursing and convalescent homes for our welfare cases, due to the fact that private nursing and convalescent homes are receiving fees way beyond the amounts the County is allowed to pay. Private nursing homes in this vicinity are receiving $25 to $60 per week, whereas we are only allowed to pay from $40 to $60 per month."—From letter of Department of Social Welfare of Erie County, April 19, 1945, signed by Thomas W. H. Jeacock, Commissioner.

Facilities for Custodial Care

"Custodial facility" and "county home infirmary" are synonymous in the minds of many of the commissioners and, as previously noted, the distinction between the role of the public home infirmaries and that of the nursing homes is not clear. This is understandable. With the advent of the various categories of public assistance, the individual dependent on government for food, shelter, fuel and clothing no longer looks to the public home for subsistence. He is given regular, periodic grants to purchase these items and make his home where and with whom he chooses. Likewise, the "county home farm" in many localities has gradually become a vestigial remain or an historic tradition, as the inmates are often physically unable to perform farm labor chores. Consequently, the county home population has more and more become one of persons unable to care for themselves outside an institution, with many of them physically disabled in varying degrees and periodically ambulant, semi-ambulant or bedridden. So the county home, and of necessity its infirmary, is slowly changing its function. Its role is merging with that of the nursing home. The time may have come when one should absorb the other and provide the dual service of nursing and custodial care in the interest of efficiency, economical operation and good standards.

In upstate New York five of every six county commissioners and more than half the city commissioners reported a lack of custodial facilities. Many consider the amelioration of this inadequacy as the primary cure-all for the problem of caring for the chronically ill and therefore advocate the expansion of their respective county home infirmaries. New York City reported that "because of the lack of custodial facilities, patients in terminal stages and those whose conditions require life care are sent to nursing homes. This creates unsound planning for the individual and a heavy financial burden on the Department of Welfare."

Although the letter of inquiry did not ask for an opinion on the social stigma which public infirmaries might still retain or the potential policy of admitting paying patients to such institutions, a number of comments were received on these points. The concensus was that steps should be taken to obviate any persisting stigma and that, in the absence of local

[8]From letter of City of New York Department of Public Welfare, May 4, 1945, signed by H. W. Marsh, Commissioner.

facilities providing similar services of comparable quality at reasonable rates, the public infirmaries should admit patients able to pay for care.

"While the word 'county home' has changed in our thinking, still there is a certain amount of stigma and a great deal of hesitancy and heartache for old people or ill people to be brought to the County Home."—From letter of Department of Social Welfare of Madison County, April 10, 1945, signed by Mrs. Geraldine Wheeler, Commissioner.

"Our chronic cases requiring nursing care, but not hospitalization with surgical or intensive medical treatment, are cared for at our County Infirmary. The former feeling against this type of care has been largely corrected by the enthusiastic endorsement of respected citizens of the various communities who have been cared for at the Infirmary and returned to their homes."—From letter of Department of Public Welfare of Cortland County, May 7, 1945, signed by Frank W. Chrisman, Commissioner.

"We also have a great many calls for patients who are chronically ill and whose means are limited. They can and are willing to pay for their relatives oftentimes if their current earnings are sufficient to pay the charge at the Infirmary, as they cannot manage on hospital or the regular nursing home rates. I feel, as time goes on, we are going to be confronted more with this type of case which means that public funds will undoubtedly have to be provided to make facilities available to care for this type of case."—From letter of Department of Welfare of Niagara County, May 4, 1945, signed by Milton E. Switzer, Commissioner.

"A great many chronically ill persons in need of hospital care are now compelled to remain in their own homes or nursing homes. Many of these patients can and are willing to pay for the full cost of care but are unable to obtain beds in private hospitals. These patients are paying their way in the County Infirmary and are therefore making it difficult for indigent persons needing hospital care to be admitted. In planning for the future it would seem that each private hospital should provide a number of beds for the chronically ill who are able to pay for their own care. However, in expanding hospital services it would be difficult for the average community to raise funds except to meet the increasing demand for care of the acute cases. The alternative would be to expand facilities with public funds, either Federal, State or local, or a combination of the three."—From letter of Department of Public Welfare of Monroe County, April 7, 1945, signed by Jesse B. Hannan, Director.

"At the present time we have patients in our Infirmary and have also received many applications from patients in the City who are able to pay their way in the Infirmary. Many patients who have been in the hospital ready to be discharged have applied to our Department for admission to the Infirmary. They have no one to care for them at home as the heads of their families are employed, and they are not able to get anyone to come into the homes to look after the patients. If we had a nursing home, these patients could be cared for in the nursing home and it would relieve the congestion in the Infirmary; or, if our Infirmary were enlarged, and the stigma of the City Home removed, it would, undoubtedly, solve our problem on nursing care."—From letter of Department of Public Welfare of the City of Newburgh, May 2, 1945, signed by T. J. Cannon, Director.

USE OF FACILITIES OUTSIDE LOCAL AREA

The local departments of public welfare tend to refer their medically indigent cases, including the chronically ill, outside the immediate territory for diagnosis and treatment when this service is not locally available. This practice is indicative of a desire to provide a high quality of care.

All the departments use the various Veterans Administration and state operated facilities for tuberculosis, mentally ill, epileptic, feeble-minded, child orthopedic and cancer cases. Because of this universality of practice, the referral of cases to such institutions is not considered in the following discussion.

Four of every five of the 83 commissioners replying to the letter, send medically indigent patients requiring specialized diagnosis and treatment outside their immediate territory when such care is not locally available.[9] This indicates that the commissioners of public welfare, in addition to having a conception of the necessity of a high quality of medical service, are willing to follow the recommendations for referrals made by local physicians, have a regard for the individual patient and a sense of public responsibility.

The following departments stated that they do not refer cases out of their territory for medical service:

Counties	*Cities*
Albany	New York
Cattaraugus	New Rochelle
Erie	Oswego
Monroe	Rochester
Schenectady	Rome
Sullivan	White Plains
Westchester	Yonkers

Most of these areas are generally considered to be medically self-sufficient. Erie County uses the facilities of Buffalo City, a medical center; Monroe County and Rochester City use the facilities of Rochester, a medical center; Albany and Schenectady Counties use the facilities of Albany, a medical center; New York City itself is a medical center; and Westchester County and its cities, New Rochelle, White Plains and Yonkers, can use neighboring New York City facilities if needed. It is doubtful that medical opinion would similarly consider as self-sufficient the facilities of Cattaraugus County, Sullivan County, Oswego City (Oswego County) and Rome City (Oneida County).

It is difficult to determine from the correspondence the frequency with which cases are referred outside of the immediate local territory. Some areas have a greater variety of high quality services than others and therefore refer cases rarely. Others, such as Hamilton county, depend largely on neighboring facilities for a major part of their medical services. Some refer cases only for such specialized services as brain and spinal surgery, while others refer a wide range of diagnostic classifications.

As previously noted, the places within the State to which the departments of public welfare most frequently refer cases are the hospitals and physicians in Albany, Buffalo, New York City, Rochester and Syracuse, all of which are medical teaching centers. Counties and cities along the southern tier of the State make frequent use of Packer Hospital at Sayre, Pa., and those in the northeastern part the hospitals in Montreal. The more rural communities refer cases to immediately neighboring cities and then, if still more specialized service is indicated, the cases are referred from the "neighboring city" to the medical centers previously named. Examples of this type of "close to home" referral are: Delaware County cases are

[9] See Table 14, pages 54 and 55, for detailed tabulation.

referred to Cooperstown, Kingston and Oneonta; Beacon City cases to Poughkeepsie; Essex County cases to Glens Falls and Plattsburgh; Hamilton County cases to Gloversville, and so forth. Some welfare departments in the eastern part of the State send terminal cancer cases to Rosary Hill at Hawthorne, Westchester County, probably because of their inability to find proper care for such cases closer to home.[10]

In more instances than one might expect, cases have been referred for exceptionally specialized services to distant medical centers rather than to those closer to the locality. Strong Memorial Hospital in Rochester is thus used for brain surgery and the hospitals in New York City for a wide range of cases. Referrals of medically indigent patients to medical centers outside the State have been made to the University of Pennsylvania Hospital in Philadelphia, Crile Clinic in Cleveland, Mayo Clinic in Rochester, Minn., Lahey Clinic and Massachusetts General Hospital in Boston and Johns Hopkins Hospital in Baltimore.[11]

SUGGESTIONS FOR PLANNING FOR THE CHRONICALLY ILL

The suggestions made by the departments of public welfare for improving the care of the chronically ill were two-fold, (1) the general types of facilities and services needed and (2) the kinds of state assistance desired.

Of the 83 commissioners replying to the inquiry letter, 64 made specific suggestions as to the type of facilities and services needed, some offering more than one suggestion. Those most frequently made related to new, enlarged and/or improved public infirmary, hospital and nursing home facilities. The need for diagnostic facilities was mentioned far less often. See Table 8, below, and Table 15, page 56.

TABLE 8. *Suggestions Made Most Frequently by the Local Departments of Public Welfare for Improving the Facilities and Services for Care of the Chronically Ill, Exclusive of Proposals for State Financial Assistance.*

SUGGESTION	Welfare Departments		
	Total	County	City
New, enlarged and/or improved public infirmaries	31	15	16
Expanded hospital facilities	[1] 21	12	9
Additional and/or more adequate nursing homes	19	10	9
Additional diagnostic facilities	8	3	5

[1] In addition, some welfare departments suggested the establishment of state hospitals.

In addition to the above suggestions, the commissioners made others less often—the establishment of institutions for the chronic alcoholic and borderline mental cases; the expansion, integration and licensure of present facilities; promotion of occupational therapy, physiotherapy, vocational training and rehabilitative services; and the use of volunteers. These proposals are listed in Table 9, below:

In commenting upon the need for adequate infirmaries in public homes, some commissioners stated that infirmaries, which they preferred to nursing homes, should admit paying patients. Others, apparently more favorable to nursing homes, advocated the improvement of existing nursing home facilities. The following excerpts illustrate these points of view.

> "It would seem to me, considering the State as a whole, that something should be done in the postwar period to provide suitable and sufficiently large county infirmaries in every county in the State so that the infirmary would be in a position to admit chronic cases which are unable to purchase adequate service and care elsewhere. There are many instances where chronic cases are financially able to pay the cost of their care in a county infirmary, but are financially unable to purchase care from an entirely private source, or unable to make arrangements to receive proper care in hospitals or nursing homes."—From letter of Department of Social Welfare of Wayne County, April 21, 1945, signed by Elmer G. Butts, Commissioner.

TABLE 9. *Suggestions Made Less Frequently by Welfare Departments for Improving the Facilities and Services for Care of the Chronically Ill, Exclusive of Proposals for State Assistance* [1]

SUGGESTION	Welfare Departments		
	Total	County	City
Boarding homes, supervision of	3	1	2
Care in own home, encouragement of	1	1	..
Clinics needed			
For diagnosis and treatment	2	2	..
Mental hygiene specifically	1	..	1
Facilities			
Coordination of licensure and inspection to maintain standards	1	1	..
Expansion and integration of present facilities	1	1	..
Expansion of voluntary facilities with aid of public funds	1	1	..
Establishment of facilities for:			
Care of the aged and chronically ill	2	..	2
Chronic alcoholics	1	..	1
Custodial care of borderline mental cases	2	1	1
Home aides, use of	1	1	..
Medical social worker in general hospital	2	1	1
Nursing homes			
Establishment of voluntary homes in connection with hospitals	1	..	1
Supervision of homes	1	..	1
Nursing service, home visiting	2	2	..
Occupational therapy	5	4	1
Physiotherapy	2	2	..
Preventive program	2	2	..
Recreation program	1	1	..
Rehabilitation services	1	1	..
Services to cancer patients	1	..	1
Training program (in-service) for public welfare personnel	1	1	..
Vocational training	1	1	..
Volunteers, use of	1	1	..

[1] See Table 15, page 56, for details.

[10] *Counties:* Cortland, Dutchess, Montgomery. *Cities:* Beacon, Gloversville, Newburgh, Troy.

[11] See Table 14, page 54, for detailed tabulation.

"The average nursing home gives care only in the daytime although a great many of the patients are just as much in need of nursing care at night. I have failed to find the nursing home which gives this kind of service. Furthermore, such homes have neither the equipment nor staff to give proper care. On the other hand, the county home is well equipped for 24-hour service seven days a week and also has the services of a licensed physician, as needed. Therefore, I am convinced that the problem must be solved by establishing public infirmaries to give the care and attention now needed and which, most assuredly, will be needed even more in the future."—From letter of Department of Public Welfare of the Town of Union, April 6, 1945, signed by H. B. Osterhout, Commissioner.

"There is a great and growing need for providing efficient care for the aged and chronically ill at a reasonable cost, for those ineligible for public assistance are anxious to retain their independence as long as possible with their limited resources. We receive many inquiries from relatives able to pay the amount it costs for care at the County Infirmary, yet who are not financially able to undertake an indefinite obligation of $15 to $25 weekly. County Infirmary care is, of course, unavailable to such private patients. The only answer that occurs to us is a convalescent hospital or institution, partially publicly sponsored and supported, where such cases might be cared for efficiently. This should not be regarded as a public assistance project, any more than a farm subsidy, or public provision for a public health problem. We believe such an institution could give much more satisfactory and efficient care than can private homes, where it is almost impossible to guarantee required standards and conditions and where prohibitive prices to this type of case always prevail."—From letter of Department of Public Welfare of Cortland County, May 7, 1945, signed by Frank W. Chrisman, Commissioner.

"The type of sanitarium or hospital that we need is one where persons of any age, or suffering from any disease or condition, may be admitted and cared for without question as to length of stay so long as need of that type of care exists. The sanitarium or hospital might be built to serve three or more counties."—From letter of Department of Public Welfare of Sullivan County, April 11, 1945, signed by Margaret G. Engert, Commissioner.

"It is our opinion that the chronically ill improve more rapidly in small convalescent homes than in institutions for that type of care. Therefore, we feel that the trend should be toward the maintenance of small convalescent homes rather than large institutions. This is especially true of the aged, who dread hospitalization and being in institutions, such as our Erie County Home and Infirmary. In other words, convalescent homes still make the individual feel that he possesses some home life and some freedom rather than that he is being tucked away in an institution which is looked upon as a 'poorhouse'."—From letter of Department of Social Welfare of Erie County, April 19, 1945, signed by Thomas W. H. Jeacock, Commissioner.

"Hypochondriacs, neurotics, senile cases, many of these are now in nursing homes. But in these homes there is no provision for recreation of any sort—no reading room or sun room—so that patients could enjoy at least a change of room. They just sit all day beside their beds or, on occasion and when able, go to each other's rooms. They do receive sufficient medical care."—From letter of Department of Public Welfare of the City of Auburn, May 5, 1945, signed by Lucile G. Chisholm, Commissioner.

"Although we have comparatively few chronic cases needing medical care in the middle age or younger age groups, the predominance of the older age group in nursing homes deters the former from entering a nursing home. It is neither pleasant nor satisfactory to have the younger people in constant association with the aged, as I feel the attitude of these older persons is detrimental to the general morale of the younger group."—From letter of Department of Public Welfare of Oneida County, May 18, 1945, signed by Mell A. Gooch, Commissioner.

As shown in Table 9, page 44, a number of isolated suggestions were made for improving the care provided the chronically ill. Though infrequently expressed, they seem prompted by careful consideration and a realistic, practical need, as illustrated by the following excerpts.

"It is recognized, however, that for some of these patients (chronically ill patients in general hospitals) there does come a time when the intensive medical services of the hospital are no longer needed. Some could be returned to a more personalized home situation, if plans could be worked out to provide 'home aides' to assist with their care and relieve family members from the burden of the constant attention they need. Others could be happily adjusted in a nursing home situation. For others the type of care offered in our County Home Infirmary would be best.

"One of the chief drawbacks in discharging chronic patients to the community is the difficulty in arranging for clinic visits. It is not certain whether this should be answered by the development of traveling clinics or by developing more adequate transportation plans for return visits to existing clinics. This especially applies to patients needing frequent x-ray treatments and pneumothorax."—From letter of Department of Public Welfare of Westchester County, May 29, 1945, signed by Ruth Taylor, Commissioner.

"In reference to adequate facilities for chronic cases needing custodial care, we have always maintained that there should be an institution intermediate between the county home and the state mental hospital. Often, and I believe really more than comes to our attention, we find not only aged but also middle-aged and young patients having senile conditions and moral habits that cannot be properly cared for in boarding and nursing homes. And they are neither proper cases for the county infirmary nor the mental hospital. The type of case I am speaking of has not advanced sufficiently far to require care in a mental hospital but it does need specialized custodial care. It is my opinion that an intermediate institution, as previously described, would be advantageous in providing proper care for this type of case which is so difficult to place."—From letter of Department of Public Welfare of the Town of Union, April 6, 1945, signed by H. B. Osterhout, Commissioner.

"We are being called upon more and more by individuals from the community for advice and help in locating nursing homes for members of their families who are chronically ill, but for whom care at public expense is not needed. It is a problem to know how far this service should be developed when we realize that there are no over-all standards or supervision of nursing homes, and no control over the type of care offered by private nursing homes. We feel this service is implicit in our duties as a public welfare department, but we would, however, feel more confident in meeting this problem if there were a more effective means of licensing nursing homes, which would assure at least minimum standards of care and of equipment for meeting the needs of the patients.

"We would suggest also the development of an in-service training program for public welfare staff around the subject of the care of the chronically ill, their problems, and their needs. That is, we feel there is need to focus attention on the total needs of the individual, and to offer the chronically ill person a continuity of service which helps him meet his social and emotional as well as his medical problems."—From letter of Department of Public Welfare of Westchester County, May 29, 1945, signed by Ruth Taylor, Commissioner.

"A broad educational program for physicians which would give them an understanding of the needs of an increasing aging population, and the coordination of the social factors in the total adjustment of the patient in

the light of his disability . . . should be suggested."—From letter of City of New York Department of Welfare, May 4, 1945, signed by H. W. Marsh, Commissioner.

"In considering any extension of existing facilities or the instituting of any new ones, we should take into account that possibly prevention facilities and habits now being encouraged will greatly reduce the number of chronically ill patients that will require institutional care, making any large expansion unnecessary. By making possible visiting nurse service, together with adequate medical services, a goodly number of cases can be cared for in the home. We believe the existing hospitals in most rural areas, with possibly some degree of expansion, can adequately care for those needing skilled nursing and intensive medical care until such time as they can be transferred to a nursing home or, when possible, to their own homes. It must be borne in mind that the home accords them the happiest surroundings and their usefulness can be best maintained by having some chore to perform. Certainly, for those who are completely helpless and permanently incapacitated, domiciliary care is all they need and is the very best plan for them. Those having no home and who are fairly normal mentally, but are physically disabled and dependent, could be cared for in nursing homes, if this service is adequately provided; or in the County Home Infirmary, depending upon the nature and circumstances of the case.

"In conclusion, may we emphasize that we believe the strengthening of the health program for the chronically ill can best be accomplished by extending our existing facilities along the lines suggested, rather than thinking too much about institutions and governmental aid."—From letter of Department of Public Welfare of Essex County, May 7, 1945, signed by Ralph G. King, Commissioner.

PROPOSED FORMS OF STATE AID

The foregoing suggestions deal with facilities and services under local operation and auspices. In addition, the commissioners submitted proposals on types of State assistance for promoting better care for the chronically ill, some voicing more than one suggestion. The desire for State leadership and assistance to arouse and vitalize local initiative, is shown by the following paragraph written by the Commissioner of Public Welfare of the City of Jamestown: "I am especially interested in this inquiry (regarding the care of the chronically ill) as it covers the least adequately cared for field of medicine in my City. In the new Medical Manual now under development, we have tried so far as possible to utilize present resources and make more adequate our own care. We believe we have today the enthusiastic cooperation of the medical profession and any development that takes reasonable cognizance of their group, I think, will continue to have their help. Construction of facilities in the City will be necessary if we are going to have proper care for our aged and chronically ill. The matter has been discussed by city officials. Any intimation of State interest and aid will receive, I am sure, their prompt attention."[12]

The most frequent proposal was for increased and/or expanded State reimbursement for services provided locally to the medically indigent chronically ill. One-third of the local departments of public welfare (28) replying to the letter advocated State reimbursement for over-all care, regardless of whether care is provided at home, in a nursing home, in a public infirmary or in a hospital. An additional one-quarter (21) favored reimbursement specifically for care in public infirmaries and a lesser number (9) financial assistance with hospitalization. See Table 10, below, and, for a detailed tabulation, Table 16, page 58.

TABLE 10. *Suggestions on Types of State Assistance Desired for the Care of the Chronically Ill*

SUGGESTION	Welfare Departments		
	Total	County	City
State reimbursement for:			
Over-all care	28	17	11
Care in public infirmaries	21	13	8
Hospitalization	9	4	5
State financial participation in capital expansion of local facilities	14	8	6
State operated facilities and services:			
Regional hospitals	8	5	3
Nursing homes	2	1	1
Diagnostic and consultative services	7	4	3
Type not specified	1	1	..
All other	39	21	18
No reply	6	1	5

The preceding Table 10 specifically lists the most frequent types of State assistance suggested and, under "all other," notes that 39 additional miscellaneous proposals for State assistance were made. The latter, no one of which was advocated by more than five welfare departments, are as follows:

- Assistance and participation in community surveys
- Clinic services
  - State aid for operation
  - State operated mental hygiene clinics
  - State operated mobile clinics
- Coordination of services of the State Departments of Social Welfare, Public Health and Education
- Education program relative to chronic illness
  - For the community
  - For practicing physicians
- Establishment of institution for borderline mental cases
- Establishment of standards for public infirmaries
- Establishment of State operated institutions for chronic alcoholics
- Establishment of State operated institutions for senile psychotic patients
- Expansion of local capital facilities with State funds on a loan basis
- Institutional care by the State for congenitally defective children under five years of age
- Laboratory services operated by the State
- Leadership in planning and coordinating local services for the care of the chronically ill
- Nursing homes (proprietary)
  - Assistance in developing program
  - Discouraging care in proprietary nursing homes
  - Establishment of quasi-public homes admitting paying patients
  - Increase rate of State reimbursement for care in nursing homes
  - Licensure and State supervision of homes

[12] From letter of Department of Public Welfare of the City of Jamestown, April 21, 1945, signed by Carroll M. Hall, Commissioner.

Nursing service in the home, State aid for
Psychiatric service for children
Removal of means test from tuberculosis hospitalization
Supervision of over-all services provided locally for the care of the chronically ill

The following statements of various commissioners express the general attitude toward reimbursement for care of medically indigent patients.

"We are also of the opinion that the State must find a way to help the localities by providing reimbursement in a wider range of programs, which would encourage providing the type of care for an individual which is best suited for his needs, rather than determining his care on the basis of who is paying for it. This, of course, has been under consideration and study in the field of the care of the tuberculous. It has also been suggested that often the availability of reimbursement under Old Age Assistance deters a change to another type of care for an elderly person where reimbursement is not available. For instance, in Westchester County we have facilities for developing a sound program for the hospital and custodial care of the chronically ill, as well as expanding the services to them in their own homes. However, this will of necessity be an expensive project, with real question whether or not the locality can support it without aid from the state."—From letter of Department of Public Welfare of Westchester County, May 29, 1945, signed by Ruth Taylor, Commissioner.

"In counties of sufficient population proper hospitals should be developed; smaller counties should be grouped or consideration should be given to erecting district state hospitals as suggested in a plan some years ago. In either case there should be state aid as the counties, large or small, cannot carry the burden of increased services of the proper kind."—From letter of Department of Public Welfare of Albany County, April 28, 1945, signed by Leo M. Doody, Commissioner.

"It is my thought that if a county would erect a modern infirmary, properly staffed and operated, the State should pay part of the cost of operation. This would do away with the types of nursing homes found in rural areas and would be one more step in social welfare advancement."—From letter of Department of Public Welfare of Livingston County, May 1, 1945, signed by J. Donald Root, Commissioner.

"The demands for hospital care for the chronically ill are constantly increasing. Counties should be encouraged to reconstruct or build new infirmaries which will meet modern hospital standards before receiving reimbursement from the State; this would require State legislation. Nursing homes may be used for convalescent care and such care is now reimbursable. Frequent supervision by a physician and registered nurse from the Welfare Department is necessary if proper standards are to be maintained."—From letter of Department of Public Welfare of Monroe County, April 7, 1945, signed by Jesse B. Hannan, Director.

"The State and Federal Governments should encourage, by subsidy when necessary, the establishment of new voluntary hospitals for diseases of the aged or the expansion of present inadequate facilities. Reimbursement to local districts for hospital and institutional care would encourage expansion of local public owned hospitals and institutions. It would seem preferable to foster the establishment of voluntary hospitals for the care of the aged and chronically ill and thereby remove the stigma of the public home and public infirmary."—From letter of Department of Public Welfare of Nassau County, April 12, 1945, signed by Edwin W. Wallace, Commissioner.

"It is my opinion that expanded County Hospital facilities are a definite answer to many of our problems. I am in favor of a County Hospital which is accessible to residents of the City of Binghamton, their friends and families; divorced from the County Jail Barracks and the County Home, with a name which does not give the connotation which so many aged people have in their minds in connection with hospital care at the County Home. I also feel that more and better supervised boarding homes giving custodial care may be available when more women who are now employed in war production return to their homes. In this connection, I believe that better care is frequently given the chronically ill in a county hospital than in nursing homes. In line with this thinking, I believe that the State Department of Social Welfare and the Federal Government should consider reimbursement in this type of hospital just as they now reimburse for nursing home care."—From letter of Department of Welfare of the City of Binghamton, April 19, 1945, signed by James H. Robinson, Commissioner.

In addition to the proposals for State reimbursement, 14 departments favored State financial participation in the capital expansion of local medical facilities. Others advocated State operated facilities for the care of the chronically ill, including diagnostic services and regional hospitals serving the patients of several counties. The following excerpt is illustrative of the latter type of suggestion.

"What should be done in the postwar period to provide better care for the chronically ill poses quite a problem to be solved. I am of the opinion, however, that certain types of cases might be cared for in properly equipped and standardized county infirmaries. I do not believe that the solution should be entirely local or solely State from the financial aspect. I might add that under medical advice, a system might be worked out whereby even though chronically ill, a case not needing too intensive care or medication, might be cared for at such a county infirmary. Care needed beyond the point just described, should be given in regional facilities maintained and operated by the State. These regional facilities could be set up in existing hospitals, using an ell or a ward therefor, or the State could erect in the various regions thereof well equipped, modern facilities operated by itself to which the cases existent in the area might be sent."—From letter of Welfare Department of City of Elmira, April 9, 1945, signed by Joseph F. Kienzle, Commissioner.

Some replies made isolated suggestions for improving present facilities and services, either under purely local initiative or with State aid, while others contained several related suggestions. Still others, as indicated in the following excerpts, expressed the need for an integrated gamut of services ranging from active medical service to rehabilitative training.

". . . the State should build or provide medical centers, probably two in number, one to be located in the metropolitan area and one in the western part of the State.

"These medical centers should be large enough to provide adequate medical and surgical care, provide occupational therapy after maximum medical and surgical benefits had been obtained by the patient and follow up cases with rehabilitation training where needed. Care for the dependents or families could be provided through public welfare grants during care, treatment and training as needed.

"Of course it is realized that many of the chronically ill could not be improved in health to the extent that they could be made employable. However, my experience with veterans has taught me that we must not consider anyone so disabled that an effort should not be made to rehabilitate them, so that they may use such remaining ability for employment as they may have. This, of course, would require a complete coordination

of the Social Welfare Department, Educational Department, Public Health Department and other State agencies. It must be remembered too, that small agencies would be unable to provide medical and rehabilitation training, as described above, and it would have to be a project of the State."—From letter of Department of Public Welfare of Schuyler County, April 11, 1945, signed by Stewart J. Coats, Commissioner.

"We feel that Putnam County has a definite need for the development of nursing homes for the care of the chronically ill. In our opinion, a nursing home should have facilities for physical and occupational therapy for the chronically ill—physical therapy to help the general condition, and occupational therapy as an aid to the mental attitude which affects the physical well being. This kind of treatment involves a considerable financial undertaking which is not always possible without help. We feel that the State could help in this instance by working out a loan or insurance subsidy plan that could be made available to competent proprietors of nursing homes. We feel that the same sort of financial plan would be very helpful to our hospital in developing special services for which there is not now any financial appropriation, such as the development of x-ray interpretation for diagnostic purposes by employing an x-ray technician, developing a therapeutic department for physiotherapy treatment and, eventually, having a medical social worker."—From letter of Department of Public Welfare of Putnam County, April 25, 1945, written by Ralph A. Smith, Commissioner.

The majority of these suggestions propose the establishment of State operated facilities and services, State reimbursement for care provided locally and State supervision of specified services. A few indicate a desire for leadership in planning and for technical assistance in properly setting up local services. An example of the latter is contained in the following paragraph:

"I believe, also, that they (the State) might assist the local communities in surveying the areas mentioned above and interpreting the needs of the community in light of the surveys made. While I recognize the responsibility for carrying out and completing plans as primarily one of the local community, the State can exercise, consolidate and supervise responsibilities and relax its regulations in regard to reimbursement for care granted."—From letter of Department of Welfare of the City of Binghamton, April 19, 1945, signed by James H. Robinson, Commissioner.

LOCAL POSTWAR PLANS

The foregoing are suggestions made for the care of the medically indigent chronically ill. But suggestions are only a beginning. Their acceptance by the community and their translation into blueprints, plans and appropriations are necessary before real progress is begun.

It therefore augurs well that the departments of public welfare of 24 counties and nine cities reported that local plans were in the process of formation. Three contemplate an expansion of hospital facilities.[13] Plans for new, expanded and/or improved public infirmaries are being considered by 19 counties.[14] In addition, Erie County and New York City plan to develop more adequate nursing home programs; Onondaga County is hopeful of establishing a medical center in connection with Syracuse University; Madison County cites the possible development of clinic and hospital service in cooperation with Colgate University; Monroe County is seeking changes in State and Federal legislation looking toward increased financial assistance to the local departments of public welfare; and Jamestown City is considering building a unit for the chronically ill in connection with its Municipal Hospital.[15]

Some local governments have submitted plans for postwar projects to the State Postwar Planning Commission for approval and possible subsequent financial assistance with detailed construction plans. As of December 26, 1945, the plans of eight counties for public home and infirmary projects had been approved by the Commission. See Table 11, page 48.

With the exception of Chemung and Ulster Counties, neither of which replied to the letter of inquiry, the departments of public welfare of the counties listed in Table 11 had reported plans for infirmary construction in reply to the inquiry.

Although desiring State financial and technical assistance, most of the departments of public welfare

TABLE 11. *Estimated Construction Cost of Specified Local Public Home Building Projects Approved by the State Postwar Public Works Planning Commission through December 26, 1945* [1]

COUNTY	Project	Estimated Construction Cost
Total		$1,745,588
Chemung	Men's dormitory at county home	300,000
Cortland	Dormitory and infirmary at county home	287,500
Essex	Improvements and additions to county home	125,000
Livingston	Construction and remodeling county home and infirmary	378,956
Niagara	Extension and improvement of county home infirmary	231,132
Sullivan	County home and infirmary	200,000
Ulster	Alterations and new construction of men's building at county home	75,000
Wyoming	County home and infirmary	148,000

[1] Adapted from *Approved State and Municipal Projects*, New York State Postwar Public Works Planning Commission, October 1, 1945, and supplementary releases for the press.

[13] Allegany and Columbia Counties and New York City.

[14] Counties of Albany, Broome, Cattaraugus, Chenango, Clinton, Cortland, Essex, Fulton, Livingston, Montgomery, Nassau, Niagara, Onondaga, Saratoga, Suffolk, Sullivan, Tompkins, Washington, Wyoming.

[15] Also see Table 17, page 60, for complete tabulation.

wish their medical facilities and services to be under local auspices and to be planned with regard to local characteristics, problems and resources. This type of local initiative is exemplified in two replies received to the letter of inquiry.

"I have worked some with Dr. Everett Case, President of Colgate University, toward a possible clinic and small hospital to be located in Hamilton County, which might be used for the university as well as for the indigent of the county. We hoped to work this out so that we would not have to ask for county funds but to date it is just in the beginning stage."—From letter of Department of Social Welfare of Madison County, April 10, 1945, signed by Mrs. Geraldine Wheeler, Commissioner.

"While I am aware of plans under discussion for district hospitals for the chronically ill, I do not believe this is the total answer for postwar action. Whatever is done for the smaller areas, rural or urban, will need State or Federal assistance to be at all significant. There has been discussion among a limited group of a development of a separate hospital for the chronically ill or those needing convalescent or nursing care. This building is suggested for construction on the grounds of the Municipal Hospital, staffed and administered by the same group of physicians. What might be done in this regard I cannot say. I do feel that the removal of chronically ill patients from their surroundings and their friends for a long period of time has, for social reasons, much opposition."—From letter of Department of Public Welfare of City of Jamestown, April 21, 1945, signed by Carroll M. Hall, Commissioner.

APPENDIX

April 4, 1945

Dear Commissioner:

The Legislative Commission on Health Preparedness is concentrating its efforts this year on the formulation of a plan for the care of the chronically ill. Dr. Edward S. Rogers, of the State Department of Health, has been appointed Medical Director of this project, and I am serving as Chairman of a small Advisory Committee.

I am very anxious to have your help in evaluating the situation in regard to the care of the chronically ill. No group of officials is more closely in contact with various phases of this problem than the Commissioners of Public Welfare and I want to be sure that your thinking on this problem is presented to the Advisory Committee.

The care of the chronically ill, exclusive of mental diseases and tuberculosis, is a problem of grave proportions and gives every indication of becoming even more important because of the progressive aging of the population. For planning purposes, a chronic illness may be defined as one of two to three months duration and having an indefinite prognosis. While a substantial part of the problem involves cases of persons in the upper age groups, it is important to remember that approximately one-half of the persons suffering from chronic illness are under the age of forty-five. This younger group includes persons suffering from blindness, deafness, heart disease, rheumatic fever, orthopedic conditions, arthritis, cancer, diabetes, etc.

Adequate care for the chronically ill involves not only care in hospitals, nursing homes and custodial institutions, but also skilled diagnostic care and treatment in the early stages of disease to see whether there is a possibility of arresting the disease and keeping the patient on a self-maintaining level in spite of his chronic disease.

Instead of sending you a questionnaire, I am outlining some of the points on which I would like your opinion. I will be most grateful if you will write me covering these points, and any others that occur to you on this subject, as fully as possible. I am interested, not so much in the present situation which is made difficult by the war emergency, but in what you think should be planned for the post-war period in the light of the problem as you have seen it in the pre-war and war period. Some of the questions on which I would like your opinion are the following:

1. Is care of the chronically ill in your territory a problem because of
   a. Lack of diagnostic services to determine the exact condition of the patient and the type of treatment needed?
   b. Lack of hospital facilities for chronic cases needing intensive medical care?
   c. Difficulty in finding adequate nursing and convalescent homes for chronic cases?
   d. Lack of adequate facilities for chronic cases needing a custodial type of care?
2. What in your opinion should be done in the post-war period to provide better care for the chronically ill?
3. Is your County planning to do anything in this field?
4. What type of case gives you the most difficulty? (Please explain fully.)
5. What do you think the State should do to help the localities to provide adequate facilities for diagnosis, medical treatment, hospital care, nursing home, and custodial care?
6. When you have a difficult case needing specialized diagnosis, is it necessary to send the patient out of your territory?
7. When care is not available in your territory, to what hospitals or clinics do you send such cases? (Please indicate the type of case and the hospital or clinic to which referred.)

I know that these questions are not easy to answer, but I am sure that you will want to have the experience of the Commissioners of Welfare given full consideration in the formulation of any State plan for the future care of the chronically ill. I would appreciate as prompt a response as possible so that I may have ample opportunity to digest the replies and make a report to the Health Preparedness Commission.

I am as always,
Sincerely yours,

Elsie M. Bond,
Secretary

TABLE 12. *Types of Chronically Ill Cases Reported As Giving the Most Difficulty to Administrators of Local Departments of Public Welfare, New York State, 1945* [1]

WELFARE DEPARTMENT	Mental Illness		Chronic Alcoholic	Senility	Requiring Extended Nursing Care	Those Insisting on Remaining in Own Homes [3]	Cardio-vascular	Arthritic	Cancer	Other	No Reply on This Question
	Non-Committable	Neurotic, Personality Problems									
Total [2]	18	9	4	21	17	5	8	6	9	16	13
County depts.	11	5	1	14	9	2	3	3	7	4	4
City depts.	7	4	3	7	8	2	5	3	2	12	9
Albany Co.	...	x	...	x	....	....	...	...	...	....	....
Allegany Co.	x	...	...	...	....	....	...	...	...	Borderline institutional cases	....
Broome Co.	x	...	...	x	....	....	...	...	x	....	....
Binghamton	x	...	...	x	....	....	...	...	...	....	....
Union (town)	...	x	x	x	....	....	...	...	...	....	....
Cattaraugus Co.	x	...	...	...	....	....	...	...	...	....	....
Olean	...	...	...	...	....	....	...	...	...	....	x
Salamanca	...	...	...	...	....	....	...	...	...	....	x
Cayuga Co.	...	...	...	x	....	....	...	...	...	....	....
Auburn	...	x	...	x	....	....	...	...	...	....	....
Chautauqua Co.	x	...	...	x	....	....	...	...	...	....	....
Dunkirk	...	...	...	...	x	....	...	...	...	....	....
Jamestown	...	...	...	x	....	....	...	x	...	Bone fractures	....
(Chemung Co.[4])	...	...	...	...	....	....	...	...	...	....	....
Elmira	...	...	...	...	x	....	x	...	...	....	....
Chenango Co.	...	...	...	x	....	....	...	...	...	....	....
Clinton Co.	...	...	...	...	....	....	...	...	x	Neuroligical	....
Plattsburgh	...	...	...	x	....	....	...	...	...	Custodial care	....
Columbia Co.	x	...	...	...	....	....	...	...	...	....	....
Cortland Co.	...	...	...	...	....	....	...	...	...	....	x
Cortland	x	...	...	...	....	....	...	...	...	Physically handicapped patients requiring care relative to personal hygiene	....
Delaware Co.	x	...	...	x	....	....	...	...	...	....	....
Dutchess Co.	...	...	...	...	x	....	...	...	...	....	....
Beacon	...	...	...	...	....	....	x	x	...	....	....
Poughkeepsie	x	...	...	...	....	....	...	...	...	....	....
Erie Co.	...	x	...	...	....	....	...	...	...	....	....
Essex Co.	...	...	...	...	....	....	x	...	...	....	....
Franklin Co.	...	...	...	...	x	....	...	...	...	....	....
(Fulton Co.[4])	...	...	...	...	....	....	...	...	...	....	....
Gloversville	...	...	...	...	....	....	...	...	...	Custodial care	....
Johnstown	...	...	...	...	x	....	...	...	...	....	....
Genesee Co.	...	...	...	...	....	x	...	...	...	....	....
Batavia	...	...	...	...	....	x	...	...	...	....	....
Greene Co.	...	...	...	x	x	....	...	...	...	....	....
Hamilton Co.	...	...	...	...	....	....	...	...	...	....	x
(Jefferson Co.[4])	...	...	...	...	....	....	...	...	...	....	....
Watertown	x	...	...	...	....	....	...	...	...	....	....
Lewis Co.	...	x	...	...	....	....	...	...	...	....	....
Livingston Co.	...	...	...	...	....	x	...	...	...	....	....
Madison Co.	...	...	...	x	....	x	...	...	...	....	....
Oneida	...	...	...	x	x	....	...	...	...	....	....
Monroe Co.	...	...	...	...	x	....	...	...	...	....	....
Rochester	...	...	...	...	x	....	...	...	...	Custodial care	....
Montgomery Co.	...	...	...	x	x	....	...	...	...	....	....
Amsterdam	...	...	...	...	x	....	...	...	...	....	....
Nassau Co.	...	...	...	x	....	....	...	...	...	....	....
Niagara Co.	...	...	...	x	....	....	x	x	...	....	....
Lockport	x	...	...	...	....	....	...	...	...	Drug addicts	....
Niagara Falls	...	...	...	...	....	....	...	x	x	Diabetic	....
Oneida Co.	...	...	...	x	....	....	...	...	...	....	....
Rome	...	...	...	...	....	....	...	...	...	....	x
Utica	...	...	...	...	....	x	...	...	...	....	....
Onondaga Co.	x	...	...	...	....	....	...	...	...	....	....
Orange Co.	...	...	...	...	....	....	...	...	x	....	....
Middletown	...	...	...	...	....	....	...	...	...	....	x
Newburgh	...	...	...	...	....	....	...	...	x	....	....
Port Jervis	...	...	...	...	....	....	...	...	...	....	x
Orleans Co.	...	...	...	...	....	....	...	...	...	....	x
Oswego Co.	...	...	...	...	x	....	...	...	...	....	....
Fulton	...	...	...	...	....	....	x	...	...	....	....
Oswego	...	...	...	...	....	....	...	...	...	....	x
(Otsego Co.[4])	...	...	...	...	....	....	...	...	...	....	....
Oneonta	...	...	...	...	....	....	...	...	...	....	x
Putnam Co.	...	x	...	...	....	....	x	x	...	....	....
(Rensselaer Co.[4])	...	...	...	...	....	....	...	...	...	....	....
Rensselaer	...	...	...	...	....	....	...	...	...	....	x
Troy	...	...	...	...	x	....	...	...	...	....	....
Saratoga Co.	x	...	...	...	....	....	...	...	...	....	....
Schenectady	...	...	...	...	x	....	...	...	...	....	....
Schuyler Co.	x	...	...	...	....	....	...	...	...	....	....
Steuben Co.	...	x	...	x	....	....	...	...	...	....	....
Corning	...	...	...	...	....	....	...	...	...	....	x
Hornell	...	...	...	...	....	....	...	...	...	Diabetic	....
Suffolk	x	...	...	...	....	....	...	...	...	....	....
Sullivan	...	...	...	...	....	....	...	x	x	....	....

TABLE 12. *Types of Chronically Ill Cases Reported As Giving the Most Difficulty to Administrators of Local Departments of Public Welfare, New York State, 1945* [1] — (Concluded)

WELFARE DEPARTMENT	Mental Illness		Chronic Alcoholic	Senility	Requiring Extended Nursing Care	Those Insisting on Remaining in Own Homes [2]	Cardio-vascular	Arthritic	Cancer	Other	No Reply on This Question
	Non-Committable	Neurotic, Personality Problems									
Tompkins Co.	...	...	...	...	x	....	...	...	...	.....	....
Ithaca	x	...	...	x	....	....	...	...	...	.....	....
Warren Co.	...	...	...	...	....	....	...	...	x	Syphilitic	....
Glens Falls	...	x	...	...	....	....	x	...	...	.....	....
Washington Co.	...	...	...	...	....	....	...	...	x	.....	....
Wayne Co.	...	...	...	...	....	....	...	...	...	.....	x
Westchester Co.	x	...	x	x	....	....	...	...	...	.....	....
Mt. Vernon	...	x	...	...	....	....	x	...	...	Tuberculous	....
New Rochelle	...	...	x	...	....	....	...	...	...	.....	....
White Plains	x	...	...	...	x	....	...	...	...	.....	....
Yonkers	...	...	x	...	....	....	...	...	...	.....	....
Wyoming Co.	...	...	...	...	x	....	...	...	x	Diabetic	....
New York City	...	...	...	...	....	....	...	...	...	Home-bound chronically ill patients Patients requiring psychiatric treatment Patients with frequent exacerbations who are rejected for care by the City Department of Hospitals	....

[1] Based upon replies to letter asking local welfare commissioners which type of chronically ill patients give them the most difficulty administratively.

[2] Does not include the following departments which sent no reply to any part of letter of inquiry: *Counties* (14): Chemung, Fulton, Herkimer, Jefferson, Ontario, Otsego, Rensselaer, Rockland, St. Lawrence, Schoharie, Seneca, Tioga, Ulster, Yates. *Cities* (9): Hudson, Kingston, Little Falls, Mechanicville, North Tonawanda, Norwich, Ogdensburg, Peekskill, Saratoga Springs.

[3] Patients who, although unable to care for themselves and have no one to care for them, insist upon remaining in their own homes.

[4] No reply from county to any part of letter.

TABLE 13. *Availability of Facilities and Services for the Care of the Chronically Ill, by Specified Local Departments of Public Welfare, New York State, 1945* [1]

WELFARE DEPARTMENT	Diagnostic Services			Hospital Facilities			Adequate Nursing Homes			Adequate Custodial Facilities		
	Lack	No Lack	NR [2]	Lack	No Lack	NR [2]	Lack	No Lack	NR [2]	Lack	No Lack	NR [2]
Total [3]	15	66	2	44	33	6	67	15	1	57	16	10
County Depts	11	31	1	26	14	3	37	5	1	33	6	4
City Depts	4	35	1	18	19	3	30	10	0	24	10	6
Albany Co		x		x			x				x	
Allegany Co	x			x			x				x	
Broome Co	x			x			x			x		
Binghamton		x		x			x					x
Union (town)		x			x		x					x
Cattaraugus Co		x			x		x			x		
Olean		x				x	x					x
Salamanca		x				x	x			x		
Cayuga Co		x				x	x					x
Auburn		x			x			x		x		
Chautauqua Co		x				x	x					x
Dunkirk		x			x		x			x		
Jamestown		x		x			x			x		
(Chemung Co.[4])												
Elmira		x		x			x			x		
Chenango Co		x			x		x			x		
Clinton Co		x				x		x			x	
Plattsburgh		x			x			x		x		
Columbia Co	x			x			x					x
Cortland Co		x			x		x			x		
Cortland		x			x			x			x	
Delaware Co		x			x		x				x	
Dutchess Co		x			x		x			x		
Beacon		x		x			x			x		
Poughkeepsie		x		x			x				x	
Erie Co		x			x		x				x	
Essex Co	x				x		x			x		
Franklin Co	x				x		x			x		
(Fulton Co.[4])												
Gloversville		x		x			x			x		
Johnstown		x		x				x		x		
Genesee Co		x			x		x			x		
Batavia		x			x			x		x		
Greene Co		x			x		x			x		
Hamilton Co.[5]	x			x			x			x		
(Jefferson Co.[4])												
Watertown		x			x		x				x	
Lewis Co		x			x			x				x
Livingston Co		x		x			x			x		
Madison Co	x			x			x			x		
Oneida		x			x		x			x		
Monroe Co		x		x			x			x		
Rochester		x		x			x			x		
Montgomery Co	x			x			x			x		
Amsterdam		x		x			x			x		
Nassau Co		x		x			x			x		
Niagara Co		x		x			x			x		
Lockport		x		x			x			x		
Niagara Falls	x			x			x			x		
Oneida Co		x			x		x			x		
Rome	x				x			x		x		
Utica		x			x			x		x		
Onondaga Co		x		x			x			x		
Orange Co		x		x			x			x		
Middletown			x	x			x			x		
Newburgh		x			x		x			x		
Port Jervis		x		x			x					x
Orleans Co		x		x			x			x		
Oswego Co	x			x			x			x		
Fulton		x			x		x				x	
Oswego		x			x		x				x	

TABLE 13. *Availability of Facilities and Services for the Care of the Chronically Ill, by Specified Local Departments of Public Welfare, New York State, 1945* [1]— (Concluded)

WELFARE DEPARTMENT	Diagnostic Services			Hospital Facilities			Adequate Nursing Homes			Adequate Custodial Facilities		
	Lack	No Lack	NR [2]	Lack	No Lack	NR [2]	Lack	No Lack	NR [2]	Lack	No Lack	NR [2]
(Otsego Co.[4])	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Oneonta	.....	x	.....	.....	x	.....	.....	x	.....	.....	x	.....
Putnam Co	.....	x	.....	x	.....	.....	x	.....	.....	x	.....	.....
(Rensselaer Co.[4])	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....	.....
Rensselaer	.....	x	.....	.....	x	.....	.....	x	.....	.....	x	.....
Troy	x	.....	.....	x	.....	.....	x	.....	.....	.....	.....	x
Saratoga Co	.....	x	.....	x	.....	.....	.....	x	.....	x	.....	.....
Schenectady Co	.....	x	.....	x	.....	.....	x	.....	.....	x	.....	.....
Schuyler Co	x	.....	.....	x	.....	.....	x	.....	.....	x	.....	.....
Steuben Co	x	.....	.....	x	.....	.....	x	.....	.....	x	.....	.....
Corning	.....	x	.....	.....	x	.....	x	.....	.....	.....	x	.....
Hornell	.....	x	.....	.....	.....	x	x	.....	.....	x	.....	.....
Suffolk Co	.....	.....	x	x	.....	.....	x	.....	.....	x	.....	.....
Sullivan Co	.....	x	.....	x	.....	.....	x	.....	.....	x	.....	.....
Tompkins Co	.....	x	.....	x	.....	.....	x	.....	.....	x	.....	.....
Ithaca	.....	x	.....	.....	x	.....	x	.....	.....	x	.....	.....
Warren Co	.....	x	.....	x	.....	.....	.....	x	.....	.....	x	.....
Glens Falls	.....	x	.....	x	.....	.....	x	.....	.....	.....	x	.....
Washington Co	.....	x	.....	.....	x	.....	x	.....	.....	x	.....	.....
Wayne Co	.....	x	.....	x	.....	.....	.....	.....	x	x	.....	.....
Westchester Co	.....	x	.....	.....	x	.....	x	.....	.....	x	.....	.....
Mt. Vernon	.....	x	.....	x	.....	.....	x	.....	.....	.....	.....	x
New Rochelle	.....	x	.....	.....	x	.....	.....	x	.....	.....	x	.....
White Plains	.....	x	.....	x	.....	.....	x	.....	.....	x	.....	.....
Yonkers	.....	x	.....	.....	x	.....	x	.....	.....	x	.....	.....
Wyoming Co	.....	x	.....	x	.....	.....	x	.....	.....	x	.....	.....
New York City [6]	x	.....	.....	x	.....	.....	x	.....	.....	x	.....	.....

[1] Based on replies received in answer to the question: " Is care of the chronically ill in your territory a problem because of: (a) Lack of diagnostic services to determine the exact condition of the patient and type of treatment needed? (b) Lack of facilities for chronic cases needing intensive medical care? (c) Difficulty in finding adequate nursing and convalescent homes for chronic cases? (d) Lack of adequate facilities for chronic cases needing a custodial type of care? "

[2] " NR " indicates no reply received on specific question.

[3] Includes replies from 83 public welfare departments (43 county and 40 city departments). Does not include the following departments which sent no reply to any part of letter of inquiry: *Counties* (*14*): Chemung, Fulton, Herkimer, Jefferson, Ontario, Otsego, Rensselaer, Rockland, St. Lawrence, Schoharie, Seneca, Tioga, Ulster, Yates. *Cities* (*9*): Hudson, Kingston, Little Falls, Mechanicville, North Tonawanda, Norwich, Ogdensburg, Peekskill, Saratoga Springs.

[4] No reply received from county to any part of letter of inquiry.

[5] County suggests that the facilities and services which it lacks should be provided on a regional basis as Hamilton County, with 4,000 population and 1,700 square miles, is not large enough for intra-county service.

[6] Counties of Bronx, Kings, New York, Queens and Richmond.

TABLE 14. *Frequency, Type of Case and Locality to Which the Local Departments of Public Welfare of New York State Refer Patients for Specialized Care Not Locally Available, Exclusive of Referrals to State Institutions and Federal Veterans Administration Facilities, 1945* [1, 2]

WELFARE DEPARTMENT	Cases Sent Out of Area?	Type Cases Referred	Places to Which Cases are Referred							
			Within New York State						Outside New York State	No Reply on This Question
			Albany	Buffalo	New York City	Rochester	Syracuse	Other		
Total [3]	...	...	13	10	20	23	10	...	...	3
County depts	...	...	8	4	10	12	6	...	...	2
City depts	...	...	5	6	10	11	4	...	...	1
Albany Co	No	...	...	...	....	....	....	...	...	...
Allegany Co	Yes	Cranial, cataract, orthopedic, general medical, diagnosis and treatment	...	x	....	x	....	...	Sayre, Pa.[4]	...
Broome Co	Yes	Brain surgery	...	...	x	....	x	...	Philadelphia	...
Binghamton	Yes	Brain and spinal surgery	...	...	x	....	....	...	Philadelphia,[5] Baltimore [6]	...
Union (town)	Yes	Not specified	...	...	....	x	....	...	Sayre, Pa.[4]	...
Cattaraugus Co	No	...	...	...	....	....	....	...	...	...
Olean	Yes	Cases recommended by local physicians	...	x	....	x	....	...	...	...
Salamanca	Yes	Not specified	...	...	....	....	....	...	...	x
Cayuga Co	Yes	Cranial	...	...	....	x	x	...	...	...
Auburn	Yes	Cranial	...	...	....	x	....	...	...	...
Chautauqua Co	Yes	Delicate surgery	...	...	....	....	....	...	...	x
Dunkirk	Yes	Persons needing specialized diagnoses	...	x	....	....	....	...	...	...
Jamestown	Yes	Brain and oral surgery, poliomyelitis	...	x	....	....	....	...	Cleveland [7]	..
(Chemung Co.[3])	...	...	...	...	....	....	....	...	...	...
Elmira	Yes	"Difficult cases"	...	...	...	x	....	...	...	..
Chenango Co	Yes	Not specified	...	...	x	....	x	...	Sayre, Pa.,[4] Boston, Rochester, Minn.[9]	...
Clinton Co	Yes	Neurological, orthopedic	...	...	....	....	....	Schenectady	Montreal [10]	...
Plattsburgh	Yes	Neurological, orthopedic	x	...	....	....	....	...	Montreal [10]	...
Columbia Co	Yes	"Patient needing specialized diagnosis"	x	...	x	....	....	Schenectady	...	...
Cortland Co	Yes	Brain surgery, osteomyelitis, eye, cancer	...	...	....	x	x	Hawthorne [11]	...	...
Cortland	Yes	Contagious diseases	...	...	....	....	x	...	...	...
Delaware	Yes	Arthritis, cancer, cataract, diabetes, gland, orthopedic, rheumatic fever, tumor, some others	x	...	....	....	....	Cooperstown,[12] Oneonta,[13] Binghamton, Kingston	...	...
Dutchess Co	Yes	Special eye cases, orthopedic, neurological, plastic surgery, cancer	...	...	x	....	....	Hawthorne [11]	...	...
Beacon	Yes	Eye, ear, throat, allergy, arthritis, cancer, orthopedic, neurological	...	...	x	....	....	Hawthorne,[11] Poughkeepsie [14]	...	...
Poughkeepsie	Yes	Brain and special cancer surgery, skin grafting, special pediatric services	...	...	x	....	....	...	...	...
Erie Co	No	...	...	...	....	....	....	...	...	...
Essex Co	Yes	Cancer, orthopedic, neurological, skin diseases, eye	x	...	....	....	....	Cambridge,[15] Glens Falls, Plattsburgh, Saranac Lake, Schenectady [16]	Montreal [17]	...
Franklin Co	Yes	Eye, kidney, other complicated cases	x	...	....	....	....	Plattsburgh	Montreal [17]	...
(Fulton Co.[3])	...	...	...	...	....	....	....	...	...	...
Gloversville	Yes	Cancer, other miscellaneous cases	...	x	x	x	....	Hawthorne [11]	...	...
Johnstown	Yes	"Difficult cases"	...	...	....	....	....	...	...	x
Genesee Co	Yes	Not specified	...	...	....	x	....	...	...	...
Batavia	Yes	Not specified	...	...	....	x	....	...	...	...
Greene Co	Yes	Cancer, psychoneurotic	x	...	x	....	....	...	Boston [18]	...
Hamilton Co	Yes	All cases	...	...	....	....	....	Gloversville,[19] Glens Falls,[20] Tupper Lake,[21] Utica [22, 23]	...	...
(Jefferson Co.[3])	...	...	...	...	....	....	....	...	...	...
Watertown	Yes	Cranial	...	...	....	x	....	...	...	...
Lewis Co	Yes	Not specified	...	...	....	....	x	Utica, Watertown	...	...
Livingston Co	Yes	"Patients in need of specialized diagnosis"	...	...	....	x	....	Warsaw [24]	...	...
Madison Co	Yes	Child guidance service, psychiatric	...	...	....	....	x	Utica [25]	...	...
Oneida	Yes	Communicable diseases, poliomyelitis	...	...	....	....	x	...	...	...
Monroe Co	No	...	...	...	....	....	....	...	...	...
Rochester	No	...	...	...	....	....	....	...	...	...
Montgomery Co	Yes	Cancer, other miscellaneous cases	x	...	....	....	....	Hawthorne [11]	...	...
Amsterdam	Yes	Brain, chest and hypertension surgery, neurological	x	...	x	....	....	...	Boston [26]	...
Nassau Co	Yes	Orthopedic surgery, neurosurgery, arthritis	...	...	x	....	....	...	...	...
Niagara Co	Yes	"Case where diagnosis is extremely difficult"	...	x	....	....	....	...	...	...

TABLE 14. *Frequency, Type of Case and Locality to Which the Local Departments of Public Welfare of New York State Refer Patients for Specialized Care Not Locally Available, Exclusive of Referrals to State Institutions and Federal Veterans Administration Facilities, 1945* [1, 2]— (Concluded)

WELFARE DEPARTMENT	Cases Sent Out of Area?	Type Cases Referred	Places to Which Cases are Referred							
			Within New York State						Outside New York State	No Reply on This Question
			Albany	Buffalo	New York City	Rochester	Syracuse	Other		
Niagara Co. (*continued*)										
Lockport	Yes	Pediatric, diabetic, fracture, alcoholic, mental cases	...	x	....	....	....	.....	.....	...
Niagara Falls	Yes	"Cases needing specialized diagnoses"	...	x	....	x	....	.....	.....	...
Oneida Co	Yes	Psychiatric, neurological	...	...	x	....	....	.....	.....	...
Rome	No	.....	...	...	....	....	....	.....	.....	...
Utica	Yes	Brain tumor	...	...	....	x	....	.....	.....	...
Onondaga Co	Yes	Brain tumor, others not specified	...	...	x	x	....	.....	.....	...
Orange Co	Yes	Not specified	...	...	....	....	....	New Rochelle	.....	...
Middletown	Yes	Not specified	...	...	x	....	....	.....	.....	...
Newburgh	Yes	Cancer, others not specified	...	...	x	....	....	Hawthorne [11]	.....	...
Port Jervis	Yes	Neurological, others not specified	...	...	x	....	....	.....	.....	...
Orleans Co	Yes	Not specified	...	x	....	x	....	.....	.....	...
Oswego Co	Yes	Not specified	...	...	....	....	x	.....	.....	...
Fulton	Yes	Difficult cases	...	...	....	....	x	.....	.....	...
Oswego	No	.....	...	...	....	....	....	.....	.....	...
(Otsego Co.[8])	...	.....	...	...	....	....	....	.....	.....	...
Oneonta	Yes	"When case needs specialist attention"	x	...	x	....	....	.....	.....	...
Putnam Co	Yes	Cancer, orthopedic, eye, ear, throat	...	...	x	....	....	Poughkeepsie [14]	.....	...
(Rensselaer Co.[8])	...	.....	...	...	....	....	....	.....	.....	...
Rensselaer	Yes	All types of cases	x	...	....	....	....	.....	.....	...
Troy	Yes	Cancer	...	...	....	....	....	Hawthorne [11]	.....	...
Saratoga Co	Yes	"Difficult cases"	x	...	x	....	....	.....	.....	...
Schenectady Co	No	.....	...	...	....	....	....	.....	.....	...
Schuyler Co.[8]	Yes	"Difficult cases"	...	...	....	x	....	.....	Sayre, Pa.[4]	...
Steuben Co	Yes	"Extreme cases"	...	...	....	x	....	.....	.....	...
Corning	Yes	Not specified	...	...	....	x	....	.....	.....	...
Hornell	Yes	Not specified	...	...	....	x	....	.....	.....	...
Suffolk Co	No Reply	.....	...	...	....	....	....	.....	.....	...
Sullivan Co	No	.....	...	...	....	....	....	.....	.....	...
Tompkins Co	Yes	"Cases needing special diagnoses"	...	...	....	x	....	.....	Sayre, Pa.[4]	...
Ithaca	Yes	Cranial	...	...	....	x	....	.....	.....	...
Warren Co	Yes	Cancer, psychiatric, "other specialized cases"	x	...	....	....	....	Cambridge [15]	.....	...
Glens Falls	Yes	Cancer, orthopedic, psychoneurotic, kidney, surgery	x	...	....	....	....	Cambridge [15]	Boston [18]	...
Washington Co	Yes	On advice of physician	...	...	....	....	....	.....	.....	x
Wayne Co	Yes	"Specialized diagnosis"	...	...	....	x	....	.....	.....	...
Westchester Co	No	.....	...	...	....	....	....	.....	.....	...
Mt. Vernon	Yes	"Difficult cases"	...	...	x	....	....	.....	.....	...
New Rochelle	No	.....	...	...	....	....	....	.....	.....	...
White Plains	No	.....	...	...	....	....	....	.....	.....	...
Yonkers	No	.....	...	...	....	....	....	.....	.....	...
Wyoming Co	Yes	Allergy, eczema, orthopedic	...	x	....	x	....	.....	.....	...
New York City	No	.....	...	...	....	....	....	.....	.....	...

[1] Based on replies received in answer to two questions: (a) "When you have a difficult case needing specialized diagnosis, is it necessary to send the patient out of your territory?" (b) "When care is not available in your territory, to what hospitals or clinics do you send such cases? (Please indicate the type of case and hospital or clinic to which referred.)"

[2] Exclusive of referrals to State hospitals for mental, epileptic, feebleminded, orthopedic and cancer patients and Federal Veterans Administration Facilities.

[3] Includes replies from 83 welfare departments (43 county and 40 city departments). Does not include the following departments which sent no reply to any part of letter of inquiry: *Counties (14)*: Chemung, Fulton, Herkimer, Jefferson, Ontario, Otsego, Rensselaer, Rockland, St. Lawrence, Schoharie, Seneca, Tioga, Ulster, Yates. *Cities (9)*: Hudson, Kingston, Little Falls, Mechanicville, North Tonawanda, Norwich, Ogdensburg, Peekskill, Saratoga Springs.

[4] Packer Hospital.

[5] University of Pennsylvania Hospital.

[6] Johns Hopkins Hospital.

[7] Crile Clinic.

[8] No reply received from county to any part of questionnaire letter.

[9] Mayo Clinic.

[10] Montreal Neurological Institute.

[11] Rosary Hill Home.

[12] Bassett Memorial Hospital.

[13] Fox Hospital.

[14] Vassar Brothers Hospital.

[15] Mary McClellan Hospital.

[16] Schenectady Hospital.

[17] Royal Victoria Hospital.

[18] Lahey Clinic.

[19] Nathan Littauer Hospital.

[20] Glens Falls Hospital.

[21] Mercy Hospital.

[22] Faxton Hospital.

[23] St. Elizabeth's Hospital.

[24] Wyoming County Community Hospital.

[25] Utica Memorial Hospital.

[26] Massachusetts General Hospital.

TABLE 15. *Suggestions of Specified Local Departments of Public Welfare for Improving Local Facilities and Services for the Care of the Chronically Ill, New York State, 1945* [1]

WELFARE DEPARTMENT	Suggestion					No Reply on This Question
	Additional Diagnostic Facilities	Expanded Hospital Facilities	Additional and/or More Adequate Nursing Homes	New, Enlarged and/or Improved Public Infirmaries	Other	
Total [2]	8	21	19	31	37	19
County Depts.	3	12	10	15	24	8
City Depts.	5	9	9	16	13	11
Albany Co.	....	x	....	....	....	....
Allegany Co.	x	x	....	....	....	....
Broome Co.	....	x	....	....	....	....
Binghamton	....	x	x	....	Supervised boarding homes	....
Union (town)	....	....	x	x	Institution for specialized custodial care of borderline mental cases	....
Cattaraugus Co.	....	....	....	x	....	....
Olean	....	....	....	....	....	x
Salamanca	....	....	....	....	....	x
Cayuga Co.	....	....	x	x	....	....
Auburn	....	....	....	....	....	x [3]
Chautauqua Co.	....	....	x	....	Boarding homes	....
Dunkirk	....	....	....	....	....	x
Jamestown	....	....	....	....	....	x [3]
(Chemung Co.[4])	....	....	....	....	....	....
Elmira	....	....	....	x	....	....
Chenango Co.	....	....	....	x	....	....
Clinton Co.	....	....	....	....	....	x
Plattsburgh	....	....	....	x	....	....
Columbia Co.	....	....	x	....	Home visiting nurse service Free clinics	....
Cortland Co.	....	....	x	....	....	....
Cortland	....	....	....	....	....	....
Delaware Co.	x	x	....	x	Encouragement of care in own home	....
Dutchess Co.	....	....	x	....	....	....
Beacon	....	x	....	....	....	....
Poughkeepsie	....	....	x	....	....	....
Erie Co.	....	....	x	....	....	....
Essex Co.	....	....	....	....	Expansion and integration of present facilities Program for prevention. Coordination of licensure and inspection of institutions to maintain standards.	....
Franklin Co.	....	....	....	x	....	....
(Fulton Co.[4])	....	....	....	....	....	....
Gloversville	....	....	....	x	....	....
Johnstown	....	....	....	....	....	x [5]
Genesee Co.	....	....	....	....	....	x [5]
Batavia	....	....	....	....	....	x [5]
Greene Co.	....	....	....	x	....	....
Hamilton Co.	....	....	....	....	....	x [3]
(Jefferson Co.[4])	....	....	....	....	....	....
Watertown	....	....	....	x	....	....
Lewis Co.	....	x	....	....	....	....
Livingston Co.	....	....	....	x	....	....
Madison Co.	....	x	....	....	....	....
Oneida	....	....	....	....	Mental Hygiene Clinic	....
Monroe Co.	x	....	....	x	....	....
Rochester	....	x	x [6]	x	Establishment of voluntary nursing homes in connection with hospitals.	....
Montgomery Co.	....	x	....	....	....	....
Amsterdam	....	....	....	....	....	x
Nassau Co.	....	....	....	....	Expansion of voluntary facilities with public financial aid. Physiotherapy. Vocational training. Occupational therapy.	....
Niagara Co.	....	....	....	....	....	x
Lockport	....	x	....	x	....	....
Niagara Falls	....	x	x	....	....	....
Oneida Co.	x	....	x [6]	x	....	....
Rome	....	....	....	....	....	....
Utica	x	....	....	....	....	....
Onondaga Co.	....	x	....	x	....	....
Orange Co.	x	x	x	x	....	....
Middletown	....	....	....	....	....	x
Newburgh	....	....	....	....	Service to cancer patients	....
Port Jervis	....	....	....	x	....	....
Orleans Co.	....	....	....	x	....	....
Oswego Co.	....	x	....	x	....	....
Fulton	....	....	....	....	Out-patient clinic for treatment, in addition to diagnosis.	....
Oswego	....	....	....	....	....	x
(Otsego Co.[4])	....	....	....	....	....	x [3]
Oneonta	....	....	....	....	....	....
Putnam Co.	....	....	....	....	....	x [5]
(Rensselaer Co.[4])	....	....	x	....	Physical therapy Occupational therapy. Medical social worker on hospital staff.	....
Rensselaer	....	....	....	....	....	....
Troy	....	....	x	....	....	....
Saratoga Co.	....	x	....	....	General facilities for aged, chronically ill. (Specific type of facilities not specified).	....
Schenectady Co.	....	....	x	....	....	....

TABLE 15. *Suggestions of Specified Local Departments of Public Welfare for Improving Local Facilities and Services for the Care of the Chronically Ill, New York State, 1945* [1]— (Concluded)

WELFARE DEPARTMENT	Suggestion					No Reply on This Question
	Additional Diagnostic Facilities	Expanded Hospital Facilities	Additional and/or More Adequate Nursing Homes	New, Enlarged and/or Improved Public Infirmaries	Other	
Schuyler Co.	....	....	....	....	Occupational therapy Rehabilitation.	....
Steuben Co.	....	....	....	....	....	x
Corning	....	....	....	....	....	x [2]
Hornell	....	....	....	x	....	....
Suffolk Co.	....	....	....	x	....	....
Sullivan Co.	....	x	....	x	....	....
Tompkins Co.	....	....	....	x	....	....
Ithaca	....	....	....	x	....	....
Warren Co.	....	....	....	....	....	x [3]
Glens Falls	....	....	....	....	Occupational therapy	....
Washington Co.	....	....	....	....	....	x [3]
Wayne Co.	....	....	....	x	....	....
Westchester Co.	....	....	x	x	Occupational therapy Recreation program. Education for prevention. Home aides. Use of volunteers. In-service training program for public welfare personnel relative to chronically ill.	....
Mt. Vernon	....	x	....	....	....	....
New Rochelle	....	....	....	....	Institution for chronic alcoholics Institution for borderline psychopathic and psychoneurotic cases.	....
White Plains	....	....	x	x	Social service departments in local general hospitals.	....
Yonkers	....	x	....	....	....	....
Wyoming Co.	....	....	....	x	Home visiting nurse service	....
New York City	x	x	x	x	Supervision of nursing home care Develop program of homes for aged. Supervised boarding homes.	....

[1] Based on replies received in answer to the question: "What in your opinion should be done in the postwar period to provide better care for the chronically ill?"

[2] Includes replies from 83 welfare departments (43 county and 40 city departments). Does not include the following departments which sent no reply to any part of letter of inquiry: *Counties (14)*: Chemung, Fulton, Herkimer, Jefferson, Ontario, Otsego, Rensselaer, Rockland, St. Lawrence, Schoharie, Seneca, Tioga, Ulster, Yates. *Cities (9)*: Hudson, Kingston, Little Falls, Mechanicville, North Tonawanda, Norwich, Ogdensburg, Peekskill, Saratoga Springs.

[3] No reply received relative to need for specific facilities or services, but welfare department did suggest need for state aid in financing care.

[4] No reply received from county to any part of letter of inquiry.

[5] Current facilities and services reported as adequate.

[6] Including facilities for convalescent care of younger age groups.

TABLE 16. *Suggestions of Specified Local Departments of Public Welfare on Types of State Assistance Desired for Care of the Chronically Ill, New York State, 1945* [1]

WELFARE DEPARTMENT	Reimbursement for:			Financial Aid in Capital Expansion of Local Facilities	Establishment of State Operated Facilities and Services				Other	No Reply to This Question
	Care in Public Infirmaries	Hospitalization	Over-all Care		Regional Hospitals	Nursing Homes	Diagnostic and Consultative Services	Type not Specified		
Total [2]	21	9	28	14	8	2	7	1	39	6
County Depts	13	4	17	8	5	1	4	1	21	1
City Depts	8	5	11	6	3	1	3	0	18	5
Albany Co	...	...	x	x	...	...	...	x	...	...
Allegany Co	x	...	..	...	...	...	x	...	Remove means test for hospitalization for tuberculosis cases.	...
Broome Co	...	...	x	...	...	...	...	...	...	...
Binghamton	x	x	..	...	...	...	...	...	Assistance with community surveys Community education.	...
Union (town)	x	...	..	...	...	...	...	...	...	...
Cattaraugus Co	x	...	..	...	...	...	...	...	...	...
Olean	...	...	..	...	...	...	...	...	...	x
Salamanca	...	...	..	...	...	...	...	...	...	x
Cayuga Co	x	...	..	x	...	...	...	...	Psychiatric service for children	...
Auburn	...	...	x	...	...	...	...	...	...	...
Chautauqua Co	...	...	..	...	...	...	...	...	General supervision by State of service for chronically ill provided as a local responsibility.	...
Dunkirk	...	...	..	...	...	...	...	...	...	x
Jamestown	...	...	..	x	...	...	...	...	...	...
(Chemung Co.[3])	...	...	..	...	...	...	...	...	...	...
Elmira	...	...	x	...	x	...	...	...	...	...
Chenango Co	x	...	..	...	...	...	...	...	State aid for free clinics	...
Clinton Co	x	...	..	x	...	...	...	...	...	...
Plattsburgh	x	...	..	...	...	...	...	...	...	...
Columbia Co	...	...	..	...	...	x	x	...	...	...
Cortland Co	...	...	..	...	...	...	...	...	Quasi-public nursing homes which will admit paying patients.	...
Cortland	...	...	x	...	...	...	...	...	...	...
Delaware Co	...	...	x	...	...	...	...	...	Community education	...
Dutchess Co	...	...	..	...	...	...	...	...	Assistance in developing nursing home and custodial home resources.	...
Beacon	...	...	..	...	x	...	...	...	...	...
Poughkeepsie	x	...	..	x	...	...	...	...	State supervision of nursing homes	...
Erie Co	...	...	x	...	...	...	...	...	...	...
Essex Co	x	x	..	x	...	...	x	...	State aid for home bedside nursing service.	...
Franklin Co	...	...	..	x	...	...	...	...	State laboratories.	...
(Fulton Co.[3])	...	...	..	...	...	...	...	...	...	...
Gloversville	x	...	..	...	...	...	x [4]	...	...	...
Johnstown	...	...	..	...	...	...	x	...	General supervision by State of service for chronically ill.	...
Genesee Co	x	...	..	...	...	...	...	...	...	...
Batavia	x	...	..	...	...	...	...	...	...	...
Greene Co	x	...	..	...	...	...	...	...	...	...
Hamilton Co	...	...	x	...	...	...	...	...	...	...
(Jefferson Co.[3])	...	...	..	...	...	...	...	...	...	...
Watertown	...	...	x	...	...	...	...	...	...	...
Lewis Co	...	...	..	...	x	...	...	...	Mobile medical unit with clinical facilities, including psychiatric.	...
Livingston Co	x	...	..	...	x	...	...	...	...	...
Madison Co	...	...	..	...	x	...	x	...	...	...
Oneida	...	...	..	...	...	...	...	...	State aid for diagnostic clinics State aid for home bedside nursing service.	...
Monroe Co	x	...	..	...	...	...	...	...	Discourage care in proprietary nursing homes.	...
Rochester	...	x	..	...	...	...	...	...	Institutional care for congenitally defective children under 5 years of age.	...
Montgomery Co	...	...	x	...	x	...	...	...	...	...
Amsterdam	...	...	..	...	...	...	...	...	...	x
Nassau Co	...	...	x	x	...	...	...	...	...	...
Niagara Co	...	...	x	...	...	...	...	...	...	...
Lockport	...	...	..	...	...	...	...	...	Assistance in finding suitable nursing homes and certifying same. Home bedside nursing service.	...
Niagara Falls	...	...	x	...	...	...	...	...	...	...
Oneida Co	...	...	..	...	...	...	...	...	Increase reimbursement for Home Relief cases in nursing homes.	...
Rome	...	...	x	...	...	...	...	...	State aid for diagnostic clinics	...
Utica	...	...	..	...	...	...	...	...	State cancer clinic	...
Onondaga Co	...	...	x	x	...	...	...	...	...	...
Orange Co	...	...	x	...	...	...	...	...	...	...
Middletown	...	x	..	...	...	...	...	...	...	...
Newburgh	x	...	..	...	...	...	...	...	...	...
Port Jervis	...	...	..	x	...	...	...	...	...	...
Orleans Co	...	...	x	...	...	...	...	...	Establishment of standards for nursing homes by the State. Establishment of standards for public infirmaries by the State.	...
Oswego Co	...	x	..	...	...	...	...	...	State aid for establishment of clinics	...
Fulton	...	...	x	...	x	...	x	...	...	...
Oswego	...	...	x	...	...	...	...	...	...	...
(Otsego Co.[3])	...	...	..	...	...	...	...	...	...	...
Oneonta	...	...	..	...	...	...	...	...	...	x

TABLE 16. *Suggestions of Specified Local Departments of Public Welfare on Types of State Assistance Desired for Care of the Chronically Ill, New York State, 1945* [1]— (Concluded)

WELFARE DEPARTMENT	Reimbursement for:			Financial Aid in Capital Expansion of Local Facilities	Establishment of State Operated Facilities and Services				Other	No Reply to This Question
	Care in Public Infirmaries	Hospitalization	Over-all Care		Regional Hospitals	Nursing Homes	Diagnostic and Consultative Services	Type not Specified		
Putnam Co	...	...	..	...	...	...	...	...	State assistance on loan basis for expansion of adequate local hospital and nursing home facilities under voluntary and proprietary auspices.	...
(Rensselaer Co.[3])	...	...	..	...	...	...	...	...	...	...
Rensselaer	...	...	..	...	...	x	...	...	...	...
Troy	...	...	..	x	...	...	...	...	...	...
Saratoga Co	...	...	x	...	...	...	...	...	...	...
Schenectady Co	x	...	..	...	...	...	...	...	...	...
Schuyler Co	...	...	..	...	x [5]	...	...	...	Coordination of State Depts. of Social Welfare, Public Health and Education.	...
Steuben Co	x	x	..	...	...	...	...	...	...	...
Corning	...	x	..	...	...	...	...	...	...	...
Hornell	...	x	..	...	...	...	...	...	...	...
Suffolk Co	...	x	..	...	...	...	...	...	State mental hygiene clinics State mental institution for senile psychiatric patients.	...
Sullivan Co	...	...	x	...	x	...	...	...	...	...
Tompkins Co	...	...	..	...	...	...	...	...	...	x
Ithaca	x	...	..	...	...	...	...	...	...	...
Warren Co	...	...	x	...	...	...	...	...	...	...
Glens Falls	...	...	x	...	...	...	...	...	State psychiatric consultation service State aid for clinic service.	...
Washington Co	...	...	x	...	...	...	...	...	...	...
Wayne Co	...	...	x	...	...	...	...	...	...	...
Westchester Co	...	...	x	...	...	...	...	...	State leadership in planning and coordination of services. Community education.	...
Mt. Vernon	...	...	..	x	...	...	...	...	...	...
New Rochelle	...	...	..	...	...	...	...	...	State assistance in establishing institution for alcoholics. State assistance in establishing institution for borderline psychopathics and psychoneurotics.	...
White Plains	...	...	x	...	...	...	...	...	State licensure of nursing homes	...
Yonkers	...	...	..	x	...	...	...	...	...	...
Wyoming Co	x	...	..	x	...	...	...	...	...	...
New York City	...	...	x	...	...	...	...	...	Broad educational program in geriatrics and gerontology for physicians. Participation in local studies.	...

[1] Based on replies received in answer to the question: " What do you think the State should do to help the localities to provide adequate facilities for diagnosis, medical treatment, hospital care, nursing home and custodial care? "

[2] Includes replies from 83 welfare departments (43 county and 40 city departments). Does not include the following departments which sent no reply to any part of letter of inquiry: *Counties (14)*: Chemung, Fulton, Herkimer, Jefferson, Ontario, Otsego, Rensselaer, Rockland, St. Lawrence, Schoharie, Seneca, Tioga, Ulster, Yates. *Cities (9)*: Hudson, Kingston, Little Falls, Mechanicville, North Tonawanda, Ogdensburg, Peekskill, Norwich, Saratoga Springs.

[3] No reply received from county to any part of letter of inquiry.

[4] For psychiatric diagnosis and treatment.

[5] Medical centers providing complete care and follow up.

TABLE 17. *Local Plans for the Improvement of Facilities and Services for the Care of the Chronically Ill as Reported by Local Departments of Public Welfare, New York State, 1945* [1, 2]

WELFARE DEPARTMENTS	Expansion of Hospital Facilities	New, Expanded and/or Improved Public Infirmary	Other
Total [3]	3	25	7
County depts	2	18	5
City depts	1	7	2
Albany Co	...	x	...
Allegany Co	x	...	...
Broome Co	...	x	...
(Chautauqua Co.[4])	...	...	...
Jamestown	...	...	Possible development of hospital unit for the chronically ill.
Cattaraugus Co	...	x	...
Chenango Co	...	x	...
Clinton Co	...	x	...
Plattsburgh	...	x	...
Columbia Co	x	...	...
Cortland Co	...	x	...
Cortland	...	x	...
Erie Co	...	...	Continuation of development of nursing home program.
Essex Co	...	x	...
Franklin Co	...	...	Not specified.
(Fulton Co.[4])	...	...	...
Johnstown	...	x	...
Livingston Co	...	x	...
Madison Co	...	...	Possible development of clinic and small hospital service in cooperation with Colgate University.
Monroe Co	...	...	Seeking changes in State and Federal legislation relative to financial aid.
Montgomery Co	...	x	...
Amsterdam	...	x	...
Nassau Co	...	x	...
Niagara Co	...	x	...
Lockport	...	x	...
Niagara Falls	...	x	...
Onondaga Co	...	x	Establishment of medical center as part of Syracuse University.
Saratoga Co	...	x	...
Suffolk Co	...	x	...
Sullivan Co	...	x	...
Tompkins Co	...	x	...
Ithaca	...	x	...
Washington Co	...	x	...
Wyoming Co	...	x	...
New York City	x	...	Development of adequate nursing home program.

[1] Based upon replies to question asking local public welfare officials whether their localities were planning improvement of facilities and services for the care of the chronically ill.

[2] Welfare departments excluded from the tabulation are:

(a) The following which sent no reply to any portion of the letter noted in footnote No. 1:

Counties (14): Chemung, Fulton, Herkimer, Jefferson, Ontario, Otsego, Rensselaer, Rockland, St. Lawrence, Schoharie, Seneca, Tioga, Ulster, Yates.

Cities (9): Hudson, Kingston, Little Falls, Mechanicville, North Tonawanda, Norwich, Ogdensburg, Peekskill, Saratoga Springs.

(b) The following which reported that their localities contemplated no improvements:

Counties (17): Cayuga, Chautauqua, Delaware, Dutchess, Genesee, Greene, Hamilton, Lewis, Oneida, Orange, Orleans, Oswego, Schenectady, Schuyler, Steuben, Wayne, Westchester.

Cities (25): Auburn, Batavia, Beacon, Binghamton, Corning, Dunkirk, Elmira, Fulton, Glens Falls, Hornell, Mt. Vernon, Newburgh, New Rochelle, Oneonta, Oswego, Port Jervis, Poughkeepsie, Rome, Rochester, Troy, Union (town), Utica, Watertown, White Plains, Yonkers.

(c) The following which did not reply to the specific question:
Counties (2): Putnam, Warren.
Cities (6): Olean, Salamanca, Gloversville, Oneida, Middletown, Rensselaer.

[3] Includes replies from 33 departments of public welfare (24 cities and 9 county departments).

[4] No reply received from county to any part of letter of inquiry.

CARE OF THE CHRONICALLY ILL: THE HOSPITAL VIEWPOINT (1946)*

FOREWORD

The chronically ill are of all ages. It is estimated that more than 40 per cent are under 45 years old. Moreover, the steadily rising proportion of the aged in our general population, following the extension of the span of life by advances in medical science, is inevitably increasing the number of persons suffering from chronic disease. Its ravages are creating demands for service and posing social as well as medical problems.

The New York State Health Preparedness Commission is working on plans to provide the needed care, to assist in the amelioration of what some have called "the number one health problem of our time." In doing so, the Commission has become aware of the inadequacy of facilities and services for the diagnosis, treatment and rehabilitation of the chronically ill, either in their own homes, in hospitals, or in institutions intermediary between the two.

Since the general hospitals are confronted daily with the problem of providing proper care for these patients, the Commission canvassed these hospitals in upstate New York in March 1945 to secure an informal expression of opinion. The replies, significant and interesting, are summarized in this report along with typical quotations describing the situation and needs. The latter are reproduced with the permission of the respective authors.

The Commission appreciates the assistance of the many administrators of general hospitals who graciously replied to the inquiry and who are the source of the information presented in the following pages.

HIGHLIGHTS

Although most chronically ill persons, especially the ambulant and semi-ambulant, can generally be properly cared for in their own homes, a substantial number require institutional care—in hospitals, in nursing homes, in convalescent homes, in medical domiciliary institutions. In March 1945 the Health Preparedness Commission, aware that the general hospitals are in daily contact with the problem, sent a letter of inquiry to those hospitals located in *New York State, outside of New York City proper*, which had been registered by the American Medical Association for 1944. They were requested to indicate (1) the extent to which their respective beds were being used by the chronically ill, (2) the arrangements which they had for transferring such patients to other places of care, (3) the needs which they considered to be unmet and (4) their conception of the role of the general hospital in caring for this type of patient.

Replies were received from three-fourths (139) of the 180 hospitals canvassed, representing almost 90 per cent of the general hospital beds in upstate New York. The major findings, assembled from the replies, are as follows:

1. Although only a few hospitals assign specific beds, floors or wings for the care of the chronically ill, four-fifths of the hospitals admit such patients. In fact, 37 reported that from 10 to over 30 per cent of their beds were thus utilized. Others stated that they admit the chronically ill whenever beds are available. Still others admit them only in emergencies.
2. Approximately three-fourths (92) of the hospitals reporting on the availability of facilities for transferring chronic patients no longer needing hospitalization, stated that they were unable to make satisfactory arrangements for referring patients to nursing home, convalescent or medical domiciliary care. This has created an unnecessarily prolonged occupancy of some hospital beds, has hampered prompt admission of other patients sorely needing hospital care and has tended to encourage policies of rejecting chronic patients.
3. In recent years the hospitals have become increasingly aware of the lack of facilities and services for the institutional care of chronic illness, especially those requisite to eliminating this "bottleneck." Nine out of ten of the administrators replying to the question on unmet needs made suggestions for new, expanded or improved hospitals, nursing homes or convalescent homes, the latter to be affiliated with general hospitals; better staffed and equipped existing facilities; more liberal payments by welfare officials for the care of the indigent ill; graduated fees commensurate with the financial ability of the non-indigent; and the promotion of various specialized medical, medical-social and rehabilitative services.
4. Only one-fourth of the administrators expressing opinions on the future role of the general hospital in this field of medical care were adverse to its assuming a fair measure of responsibility for the care of the chronically ill. Three-fourths favored such a role, many with limitations, i.e., placement in separate wards, wings or buildings. Many would admit patients for diagnosis and screening only and others for specialized treatment only. Several replies citing the increase of the aged in the general population and efficaciousness of new treatment methods in shortening the hospitalization periods of some acutely ill cases, expressed the hope that general hospitals would re-evaluate their policies in the light of the needs of the chronically ill.

INTRODUCTION

Although some general hospitals do not, as a policy, provide long-term care for the chronically ill, it is well known that many accept such patients needing hospitalization and that, often, they are unable to discharge these individuals at the time such discharge is medically indicated because of a lack of appropriate and adequate facilities to which these patients might be transferred. To obtain further information on this point, the Health Preparedness Commission in March 1945 wrote to the administrators of all gen-

* This material, Suggestions of Administrators of General Hospitals on Planning for Care of the Chronically Ill, was previously published in mimeographed form by the Commission, the Foreword bearing the signature of Hon. Lee B. Mailler, Chairman.

eral hospitals of upstate New York which were registered by the American Medical Association for 1944, requesting information on the extent to which these hospitals were serving the chronically ill, and inviting suggestions on planning for this type of patient. (See facsimile of letter of inquiry, page 70.) Although the addressees were free to reply in detail, and were not limited by the confines of a questionnaire, four specific questions were asked, as follows:

1. Approximately what proportion of beds in your institution is assigned to the care of individuals because of chronic illness? (Chronic illness was defined as being one of two to three months duration with an indefinite prognosis, or a disease of an irremediable nature.)
2. Do you have satisfactory arrangements for referring chronically ill individuals who require further hospital care to institutions, i.e., suitable nursing homes, convalescent homes or similar institutions?
3. If there appear to be unmet needs for hospital, clinic, or other services for the medical care of these individuals in your community, what do you consider these needs to be?
4. What is your opinion with regard to the role that the general hospital should play in the care of the chronically ill?

HOSPITALS REPLYING TO INQUIRY

Replies were received from 139 hospitals in upstate New York.[1] This represented over three-quarters of the general hospitals and almost nine-tenths of the bed capacity in that area. In this connection, it should be noted that a greater portion of the larger hospitals than the smaller hospitals tended to reply to the inquiry. See Tables 18 and 19.

TABLE 18. *Number, Bed Capacity and Admissions of General Hospitals Registered by the American Medical Association in 1944, by Status of Reply, New York State, Exclusive of New York City* [1]

STATUS OF REPLY	Hospitals	Beds	Admissions
Total	180	22,155	[2] 522,951
Replying to inquiry	139	19,421	456,389
Not replying to inquiry	41	2,734	[2] 66,562
Per cent of total replying	77.2	87.7	87.3

[1] Adapted from detailed data shown in Tables 26 and 27, pages 71 to 73.
[2] Exclusive of Corinth Hospital, Middletown Sanitarium and Hospital, and Onondaga General Hospital which did not report admissions for 1944 to the American Medical Association.

[1] In addition, the replies received from six other hospitals indicated that these were special hospitals and should not, therefore, be included in the analysis. These hospitals are: Buffalo Eye and Ear Hospital, Children's Hospital (Buffalo), Masonic Soldiers and Sailors Hospital (Utica), Moses Taylor Hospital (Lackawanna), Oneida County Hospital (Rome), Ross Sanatorium (Brentwood).

TABLE 19. *Number of General Hospitals Registered by American Medical Association and Number of Hospitals Replying to Inquiry, by Size of Hospital, New York State, Exclusive of New York City* [1]

SIZE OF HOSPITAL (No. of Beds)	Total Number of Hospitals	Hospitals Replying to Inquiry	
		Number	Per Cent of Total Number
Total	180	139	77.2
Under 25	21	10	47.6
25 to 49	30	20	66.7
50 to 99	48	35	72.9
100 to 199	55	50	90.9
200 to 299	14	12	85.7
300 and over	12	12	100.0

[1] Adapted from detailed data shown in Tables 26 and 27, pages 71 to 73.

By far the greatest proportion of the hospitals (four-fifths) included in this survey were under church and non-profit auspices and a relatively small proportion (one-eighth) under public auspices. Only a few were under individual or corporate management. As a group, these hospitals were occupied to three-quarters of their combined capacities during 1944, a rather high occupancy rate. The degree to which they were used varied with size, as the larger ones were used more fully than were those of smaller size. See Tables 20 and 21.

TABLE 20. *Number and Capacity of General Hospitals Replying to Inquiry, by Auspices, New York State, Exclusive of New York City* [1]

AUSPICES	Hospitals		Beds	
	Number	Per Cent Distribution	Number	Per Cent Distribution
Total	139	100.0	19,421	100.0
Voluntary	112	80.6	14,882	76.6
Church	25	18.0	3,462	17.8
Non-profit association	[2] 87	62.6	11,420	58.8
Proprietary	10	7.2	489	2.5
Individual	6	4.3	167	0.9
Corporation	4	2.9	322	1.6
Public	17	12.2	4,050	20.9
City	11	8.0	2,254	11.6
County	3	2.1	1,560	8.1
State-County	3	2.1	236	1.2

[1] Adapted from detailed data shown in Table 26, pages 71 and 72.
[2] Includes the combined unit of Strong Memorial-Rochester Municipal Hospital.

TABLE 21. *Number, Capacity, Average Daily Census and Per Cent Occupancy of General Hospitals Replying to Inquiry, by Size of Hospital, New York State, Exclusive of New York City* [1]

SIZE OF HOSPITAL (No. of Beds)	Number of Hospitals	Bed Capacity	Average Daily Census	Per Cent Occupancy
Total	139	19,421	14,798	76.2
Under 25	10	177	118	66.7
25 to 49	20	704	430	61.2
50 to 99	35	2,533	1,900	75.0
100 to 199	50	6,851	5,256	76.7
200 to 299	12	2,836	2,164	76.3
300 and over	12	6,320	4,930	78.0

[1] Adapted from detailed data shown in Table 26, pages 71 and 72.

HOSPITAL BEDS USED FOR THE CHRONICALLY ILL

In general, the replies indicated that the provision of hospital care for chronically ill patients is recognized as a definite problem by the general hospitals. Beds intended and needed for the acutely ill are reported to be used by chronically ill patients, with the result that at times admission must be denied to acutely ill patients in need of hospital care.

Relatively few hospitals assign specified beds, floors or wings to chronic patients. The replies to the question on this point show that "assigned" was often interpreted to mean "occupied," since many hospitals known to have no specially assigned beds nevertheless stated an estimated percentage of beds occupied by chronically ill patients.

Of those replying to the question, over 40 per cent of the hospitals reported a definite proportion of beds used by chronic patients. The majority of these estimated that less than 20 per cent of their beds are so occupied. Almost 70 per cent of the hospitals do accept chronic patients, the remaining 30 per cent either do not admit them or do so only under special circumstances. See Table 22.

TABLE 22. *Use of General Hospital Beds for Chronically Ill Patients*

Reply to question: "What proportion of beds in your institution is assigned to the care of individuals because of chronic illness?"		Hospitals
Total		139
Reporting proportion of beds used by the chronically ill		57
Less than 10 per cent	20	
10 to 19 per cent	21	
20 to 29 per cent	8	
30 per cent and over	8	
Beds used by percentage not given		26
No beds assigned but accept chronically ill patients when beds are available or when room can be made for them		9
Admit chronically ill patients only in emergencies, transfer them at end of specified period, admit only as temporary measure, try not to admit them, etc.		13
No chronically ill patients admitted		28
No reply to question		6

The problems created by the pressure upon the hospitals to admit the chronically ill, the difficulties inherent in their care and the effect of their admission upon service to the acutely ill were consistently and simply stated in letter after letter. They are illustrated in the following excerpts from letters received in reply to the Commission's inquiry:

"We have no beds regularly assigned for chronic patients but, under your broad interpretation of chronic illness, probably 20 per cent of our patients would come under that category. In this 20 per cent are included orthopedic cases."—From letter of M. E. Sawtelle, Assistant Superintendent, Binghamton City Hospital, May 10, 1945.

"None of our beds are specifically assigned to the care of individuals because of chronic illness. We try not to admit the chronically ill but, from time to time, we do have patients who are with us for long periods of time—periods extending from three months to several years. We have had one polio case for many years, another compensation case that has been with us for 10 years and still another case in our men's medical ward who has been here for over two years. We recently succeeded in having a man who has been with us for several years transferred to a nursing home under the jurisdiction of the local welfare department. On one occasion recently, the chief of our medical service told me that in twelve beds in our men's medical ward there was only one acutely ill patient—all the rest were elderly men, more or less chronically ill. Obviously there is need in this community for some hospital to establish a department of geriatrics which will handle types of patients which, as you know, fall between the acutely ill and the chronically ill."—From letter of Joseph J. Weber, Administrator, Vassar Brothers Hospital, Poughkeepsie, April 10, 1945.

"No beds have actually been assigned in our institution for the care of the chronically ill but, at the moment, I should say about fifteen to twenty per cent of our beds are being occupied by chronically ill."—From letter of Myrtle DeYoung, R. N., Superintendent, John T. Mather Memorial Hospital, Port Jefferson, April 9, 1945.

"Arrangements for referring chronically ill patients who require further hospital care to other institutions or homes have never been entirely satisfactory. Even before the present national emergency (war), there was a long interval between the time the patient was ready for discharge and the actual transfer of the patient. This situation has grown steadily worse during the last several years, and a spot check last month revealed that one hundred and fifty-two of our patients were eligible for discharge to the County Infirmary, convalescent homes, or private nursing homes. This means that approximately one-third of our adult beds are used for this type of patient at a time when we are turning away acutely ill patients. We see no relief in the future."—From letter of L. J. Bradley, Assistant Director, Strong Memorial Hospital, Rochester, June 14, 1945.

"There are no beds assigned for this purpose (care of the chronically ill) in our 55 bed hospital as there are no facilities for chronically ill. However, our records show that approximately thirty per cent of our bed capacity is filled with chronically ill patients."—From letter of Sister M. Francesca, R. N., Superintendent, St. Francis Hospital, Port Jervis, May 18, 1945.

"In addition to those in private accommodations, about two-thirds of the beds in our two six-bed wards are used for chronically ill patients. One-third of these patients cannot be transferred to their homes because their families will not assume care, due to their working or not wanting to be bothered in caring for chronically ill patients. The other one-third have no home, and we have no other place to which we can refer them. This is not because they are not able to pay for their care, but because the nursing homes in this vicinity are not set up to care for chronically ill, bedridden, paralytic, old fracture, and cancer patients.

"I feel that the general hospital should be open to all patients who are referred to it by the doctors, but after

a period of two months, if nothing can be done in the general hospital for them, I believe that they should be transferred somewhere and their space given to others who really need to enter the hospital."—From letter of Mrs. Helen C. Anthony, Superintendent, Ilion Hospital, April 13, 1945.

"In the Glens Falls Hospital we cannot definitely assign any beds to the care of individuals for the treatment of chronic illness. Our facilities are constantly in demand for the care of the acutely ill and, if our beds are occupied by the long term or custodial type of patient, it means we cannot take care of the acutely ill. We have been operating for the past two years at 90 to 100 per cent of capacity and even more, at times. However, I estimate that 20 to 25 per cent of our patients are of the chronically ill type and, if they could be transferred to nursing homes, we would be in a much better position to take care of the acutely ill. There is no doubt that the number of 'chronic' sufferers is on the increase, and it is a problem to know what to do with this type of patient. The proportionate number of the older individuals suffering from the degenerative diseases is increasing rapidly."—From letter of Edward A. B. Willmer, Superintendent, Glens Falls Hospital, May 18, 1945.

"Meadowbrook Hospital is a general hospital of 250 beds owned and operated by the County of Nassau. Approximately 15 per cent of the beds in the hospital are occupied by patients having inoperable cancers, cardiovascular disease, diabetic gangrene or elderly people with injuries such as fractured hips, etc."—From letter of A. J. McRae, M. D., Superintendent, Meadowbrook Hospital, Hempstead, April 5, 1945.

"We have 80 adult beds available and we feel that we can safely say that we have eight to ten per cent occupancy by chronic cases. This is a great hardship to us as we are pressed to care for the acute cases which come to us for admission. Also, the nursing care is a problem. This type of patient many times makes our two-bed or four-bed rooms not desirable for acute cases and, by the same reasoning, the acute cases make the accommodations not desirable for the chronic patient."—From letter of June Moe, R. N., Superintendent, Oneida City Hospital, July 6, 1945.

Despite shortages of personnel and demands to admit acutely ill persons, many hospitals have attempted to either care for the chronically ill themselves or have suggested alternate places of care. This attitude is exemplified in the following comments:

"Due to the present nurse shortage and overcrowded nursing homes, we have been forced to treat a small number of chronic cases, but we do not encourage such care because we are overcrowded with acute cases. We have also found that when a convalescent home is available, the rates are too high for the average person to meet, especially if long-term care is desired."—From letter of Sister M. Madeline, Superintendent, St. Agnes Hospital, White Plains, July 5, 1945.

"Due to crowded conditions, we have no beds especially assigned to chronic cases. We take them in whenever we can and, if we cannot place them, there are two convalescent homes in the city which we make use of. However, there is a definite need for suitable nursing care for the chronically ill and aged. We believe that when we build our new hospital, in the very near future, our accommodations will be much better in this regard."—From letter of Sister Mary Aileen, Superintendent, St. Jerome Hospital, Batavia, May 17, 1945.

NEED FOR OTHER INSTITUTIONAL FACILITIES

Even those chronically ill patients who require hospital care, in most instances eventually reach a stage when transfer is indicated, if not to their own homes, then to some intermediary institution. On the whole, the hospitals reported that arrangements for consummating such transfers were unsatisfactory. Approximately three-fourths of those replying to the question stated that they were unable to find acceptable facilities to which they could refer chronically ill patients for nursing, convalescent, or medical domiciliary care when they were no longer in need of the medical services of the general hospital. This was in spite of the administrators' evident eagerness to discharge such patients in order to provide beds for the acutely ill. The lack of sufficient institutional facilities was offered in most instances as a reason for the difficulty in referring chronically ill patients to other care.

In some localities, existing institutional facilities for both indigent and pay patients are overcrowded and it is necessary to wait several weeks and sometimes months for an available bed. The stigma attached to the county home and the preference for the hospital on the part of patients and their families are mentioned in a few instances as presenting difficulties. In some areas, there are no facilities other than the county homes or infirmaries; in others, where nursing or convalescent homes are available for pay patients, the established rates are beyond the means of the average family.

The poor quality of the service and equipment of the existing institutions and the inability of those institutions to accept certain types of patients is mentioned specifically by 20 administrators as a reason for the unsatisfactory arrangements. However, it is believed that this feeling is actually more widespread, but is not specifically mentioned, since it is given expression in the statement that "suitable" facilities are not available. Some variations in the replies from administrators of hospitals within the same locality have been noted, i.e., one hospital administrator may say that he is able to make satisfactory arrangements for referring chronically ill patients to other care, whereas the superintendent of another hospital in the same area may state that he is not able to make satisfactory arrangements for such referrals. A full understanding of these variations would require further study of the individual arrangements for these hospitals. Nevertheless, it is thought that they may be explained in part by differences in opinions relating to standards, possible religious affiliations and control, and consideration of the question on the basis of prewar conditions in some instances as compared with present conditions in others. See Table 23.

TABLE 23. *Arrangements for Referring Chronically Ill Patients from General Hospitals to Other Care*

Reply to question: "Do you have satisfactory arrangements for referring individuals who require further care to institutions?"		Hospitals
Total		139
Arrangements satisfactory		21
Arrangements not satisfactory		[1] 92
Insufficient facilities	82	
Institutions are of poor quality or poorly equipped and staffed	20	
Relatives prefer hospital to other facilities	3	
Patients reluctant to go to county or city institutions	5	
Rates charged are beyond means of average family	15	
No reason given	5	
No need to refer patients, hospital meets needs		3
Arrangements made by families or others		2
No reply to question		21

[1] Total number of hospitals stating or indicating that arrangements for referring patients are not satisfactory. More than one reason or explanation may be tabulated for any one hospital.

In discussing unmet needs, the majority of the hospital administrators cited either the lack of sufficient beds in nursing homes or the poor quality of their service. One hospital superintendent described the unsuccessful effort of his hospital to make this type of care available to the community. The following quotations are typical:

> "We do not have satisfactory arrangements for referring chronically ill patients who require further hospital care. There are a number of so-called nursing homes but none of them are really satisfactory.
>
> "One of the greatest needs in this community as well as in most communities is provision for adequate chronic and convalescent care. This could best be provided by having units operated in connection with acute general hospitals, and at least one fairly large chronic hospital for such cases as would not be benefited by treatment in a chronic unit in a general hospital."—From letter of Christopher G. Parnall, M. D., Medical Director, Rochester General Hospital, April 5, 1945.
>
> "The County Hospital at present does not accept the chronically ill, if any unusual medication or any special diet is needed, because of limited medical supervision, nursing care and equipment. Inmates becoming acutely ill are returned to the general hospitals. Also, the County Hospital is practically limited to providing custodial care to senile patients and bed care to those who need only to be kept clean and fed. Convalescent homes are almost as inadequate. We need facilities to care for the senile dementia, custodial care, terminal cancer cases and for patients requiring long periods of care because of cerebral accidents and fractures among the aged."—From letter of Dorothy Pellenz, Superintendent, Crouse-Irving Hospital, Syracuse, April 20, 1945.
>
> "We do have difficulty in moving patients from our convalescent ward. The difficulty arises primarily from the fact that the Erie County Home and Infirmary is several miles from the City of Buffalo. Relatives of patients eligible for the Erie County Home very frequently resist our efforts to transfer patients out of the City, their primary reason being that they will be unable to visit the patients. In many instances these people are unreasonable in their demands. They will not assume responsibility in taking their older relatives, usually mothers and fathers, into their own homes, and use all sorts of methods to force us to keep them in our convalescent ward rather than transfer them to the Erie County Home."—From letter of William T. Clark, M. D., Superintendent, Edward J. Meyer Memorial Hospital, Buffalo, May 19, 1945.
>
> "A few years ago our managers remodeled one section of the hospital, converting a large ward in one wing of the first floor into a group of six private rooms with modern furniture. Each has hot and cold water with an adjoining sun parlor provided with heat throughout the year and double storm windows to insure comfort to the occupants of the sun parlor during the winter. Twenty thousand dollars was used for the alterations and furnishings. It is a complete and modern unit which, in addition to the above mentioned rooms, includes a reception or waiting room.
>
> "The plan was to provide for 'incurables.' However, we used the term 'chronically sick.' When it was ready for occupancy we advertised in local papers and in other communities. The rates were twenty-five dollars per week as our managers planned to absorb ten dollars per week of the thirty-five dollars, the actual cost of operation. This was based on the conviction that chronically sick people usually use most of their money in seeking relief and can only avail themselves of such service as might be obtained at a low cost. The result was that, even with the service being given at ten dollars per week less than the cost, there was no demand. There were inquiries and many expressed the desire to become patients but could not pay the price. The plan was abandoned and the facilities are now available to general hospital patients at a cost rate."—From letter of I. W. J. McClain, Superintendent, St. Luke's Home and Hospital, Utica, April 11, 1945.

Any inquiry as to the availability of satisfactory arrangements for transferring the chronically ill from hospitals is closely related to consideration of the facilities and services needed to improve the general quality of care. In this connection, nine out of every ten administrators replying to the question mentioned specific needs. Numerous suggestions were made for new, expanded or improved facilities for institutional care of the chronically ill. Some administrators stated that more adequate welfare payments, and payments by local departments of public welfare only to institutions meeting definite standards, are needed in order to raise the standards of existing institutions. That relatively few needs other than those relating to institutional care were mentioned probably is a reflection of the fact that the provision of institutional care is the problem which most immediately confronts the general hospital administrators, and thus overshadows consideration of the need for other services, such as clinics, follow-up care and provisions for teaching and research. See Table 24.

Coincident with the inquiry made of administrators of general hospitals, the commission cooperated with the New York State Association of Public Welfare Officials in conducting a similar inquiry among local welfare commissioners. The latter findings have been analyzed and published.[2] It is highly significant

[2] New York State Association of Public Welfare Officials in cooperation with the New York State Health Preparedness Commission, *Suggestions of Local Commissioners of Public Welfare on Planning for Care of the Chronically Ill*, 1945. (Reprinted supra, pages 37 to 60, under the title Care of the Chronically Ill—The Local Public Welfare Viewpoint.)

to note that high on the list of unmet needs, as seen by both groups, is the nursing home type of care of good quality at rates possible for the average person and at public expense for the medically indigent. Both groups envisage the potentiality of improved public home infirmaries. Both groups have expressed the desire for some official regulation of proprietary nursing homes. In addition, many hospitals also note the desirability of having the nursing or convalescent type of facility affiliated with the general hospital to insure a high quality of care and a smooth transfer of patients from one facility to the other, as medically required. The following comments illustrate these points:

"I believe a 40 or 50 bed nursing home run by or under the supervision of doctors and registered nurses would be of great value to this community. There are the usual percentage of chronically ill persons in this area, the care of whom is difficult at times and beyond the abilities of their families to cope with. Such a place would be near enough for frequent visits."—From letter of Mary K. Wiseman, R. N., Superintendent, Veterans Memorial Hospital, Ellenville, July 18, 1945.

"There is a definite need for facilities for the medical care of chronics in this locality—in fact, Madison County as a whole has very limited accommodations for such cases. There is a demand for accommodations for those desiring private rooms as well as those who are financed by some welfare agency."—From letter of June Moe, R. N., Superintendent, Oneida City Hospital, July 6, 1945.

"We believe that the State should take an interest in assisting qualified persons to establish nursing homes. The State Department of Social Welfare, through the licensing power, could be of great assistance in aiding prospective nursing home operators in establishing such institutions. The local welfare departments should increase their rates so that the institutions could provide adequate care."—From letter of Carl P. Wright, Jr., Superintendent, United Hospital, Port Chester, March 29, 1945.

"There are a great many people who need care who probably never will improve, but who live on for a long period of time. The average home is not a satisfactory place in which to care for these people. In this community there are quite a number of nursing homes the quality of which, I think, is very poor and the price very high. Right now even they are filled to capacity at rates from $20 to $40 per week, most of them charging approximately $30. People are earning good money now and, with two or three members of the family clubbing together, they can afford this. But the time is not far distant when I think the economic situation will not permit such an arrangement. What then?

"I do not think these people belong in a general hospital unless, in connection with such a hospital, you set up a convalescent section which would be entirely separated from the general hospital program, but operated by the hospital as an auxiliary unit. My ingenuity has been very definitely taxed on many occasions in an attempt to suggest ways and means for the care of some of these older people. I have suggested on every occasion possible that the County plan a program separate from the County Home, which has its stigma. The care of the patient able to pay a nominal fee might be subsidized by the County or by the State."—From letter of Robert L. Eckelberger, Administrator, Charles S. Wilson Memorial Hospital, Johnson City, March 30, 1945.

"The accommodations for convalescent and 'chronic' patients in Rochester are very limited. Long waiting lists in convalescent homes make it necessary for the existing hospital to care for a great number of convalescent and 'chronic' patients."—From letter of Harriet G. Moore, Superintendent, Park Avenue Hospital, Rochester, March 31, 1945.

"The greatest need, as I see it here in Troy, is for an institution under the direction of hospitals which would give adequate medical and nursing care to patients for whom there is no hope for recovery, as well as for those whose recovery may take months and who need only nursing care. I also feel that a sliding scale of rates is highly important, because so many consider it a disgrace to go to the county institution."—From letter of Helen L. Warren, Superintendent, Samaritan Hospital, Troy, June 5, 1945.

"The Board of Supervisors for Tompkins County is now considering plans for building a new infirmary which, I understand, would provide for the chronically ill. I am hopeful that a plan can be worked out whereby these beds might be built adjacent to the existing beds for acute illnesses.

"In my opinion this should be done as the special facilities in the general hospital for diagnosis and treatment, such as laboratory, x-ray, physical therapy, etc., would be available, thus avoiding a costly duplication.

"Most important, better medical care would be provided for the chronically ill with such a plan."—From letter of Irene E. Oliver, Superintendent, Tompkins County Memorial Hospital, Ithaca, April 5, 1945.

TABLE 24. *Unmet Needs for the Care of the Chronically Ill*

Reply to question: "If there appear to be unmet needs for . . . the medical care of these individuals in your community, what do you consider these needs to be?"		Hospitals
Total		139
Needs reported for care of the chronically ill		[1]101
Hospital, nursing home or convalescent facilities	91	
New facilities or expansion of present facilities	67	
Improvement in quality and equipment of present facilities	18	
Facilities with provision for fees in accordance with ability to pay	17	
Additional facilities for indigent patients	11	
Additional personnel for present facilities	10	
New or additional facilities for certain types of patients	6	
Additional general hospital beds	5	
Publicly owned home or hospital	3	
Facilities close to the community	1	
More adequate welfare payments	2	
Nursing care and training	7	
Clinics	4	
Physicians specializing in geriatrics	1	
Public education	1	
Social workers	1	
Occupational therapy	2	
Definite needs but not described	1	
Reporting no needs		11
No reply to question		27

[1] Unduplicated number of hospitals, although two or more needs may have been stated and tabulated for any one hospital.

"If you will allow me to make a suggestion, as I understand it at the present time, Old Age Assistance is not furnished to pay for those cases going to the County Home. This law should be amended because it throws the whole burden on the town and county. These people should receive Old Age Assistance from the State and Federal Governments just as readily in an institution, such as the above, as when placed in a private nursing home."—From letter of Ruth S. Geweye, Superintendent, Lewis County General Hospital, Lowville, May 11, 1945.

Closely related to the nursing home type of service is the need for an institution, or a special wing or ward, for the chronically ill who, although somewhat mentally disoriented, are not customarily considered eligible for admission to State mental hospitals. As in the case of the replies from the commissioners of public welfare, this problem has been cited by the hospital administrators, although not to as great a degree.

"I think that these patients (the chronically ill) need the good nursing care that they get in a hospital but when they become disoriented, as many of them do, they should be in wards with similar cases or transferred to a nursing home equipped to give the adequate nursing care."—From letter of Estella Douglas, R. N., Superintendent, Medina Memorial Hospital, May 14, 1945.

Although most administrators seem to think in terms of admitting the chronically ill to general hospitals, when medically indicated, others believe that special institutions should be established for this class of patient to provide all the various types of services needed—hospitalization, nursing home care, convalescent care, custodial care.

"We very much need a chronic disease hospital in this area. We believe that our present Onondaga County Hospital, with some alterations and additions, would provide such care. I have recently attended a meeting of a medical advisory board of the County Hospital in which consideration was begun on ways and means of providing the additional facilities to fill our needs."—From letter of L. M. Hickernell, M. D., Superintendent, Hospital of the Good Shepherd, Syracuse, March 29, 1945.

"With all the millions of dollars that this State is spending and is going to spend on roads, bridges, public buildings, etc., it seems a shame that it cannot set aside and maintain institutions of the same type for the care of these chronically ill people as it does for the care of the insane. If this State would maintain as good an institution for the care of chronically ill people, who are not mentally ill, it would be a great step forward. . . .

"If this State were zoned for chronically ill people the same as it is zoned for mentally ill patients, and the same type of hospital care were provided for them, on a pay basis for those who could pay and on a charity basis for others, it would be a Godsend. That, in brief, is my opinion."—From letter of George S. King, M. D., Dr. King's Hospital, Bay Shore, May 16, 1945.

As previously stated, there was a tendency for the administrators to note the need for institutional facilities rather than those services appropriate for the ambulant out-patient or for the individual under care in his own home. Since it is estimated that approximately 85 per cent of the chronically ill—the ambulant semi-ambulant and bedridden—may remain in their own homes, any suggestions for the improvement of their care seems most important. The following statement is, therefore, particularly pertinent to the non-institutional patient:

"There are no clinic facilities for the chronically ill except State sponsored orthopedic and chest clinics. More public health nurses are needed and also public education regarding the services which the public health nurse is qualified and equipped to render. Physicians do not utilize the public health nurses to the best advantage. There is also a need for social case workers in this county."—From letter of Carolyn M. Wicks, R. N., Superintendent, Soldiers and Sailors Memorial Hospital of Yates County, Penn Yan, May 15, 1945.

ROLE OF THE GENERAL HOSPITAL

With regard to the role of the general hospital in caring for the chronically ill, one-quarter of the administrators who replied to this question stated that hospitals should not be responsible for such patients. An analysis of the reasons given for this opinion indicates that consideration was not given to the possibility of separate buildings attached to or associated with the general hospital and under its supervision for medical and nursing care. Reasons which might be classed in this category are as follows: Different types of personnel and specialization would be needed. It would increase the cost of chronic cases. Separate institutions are more efficient and economical. Chronic illness is not good for nursing training or cannot be used for nursing training credit. The beds are needed for acute cases. The hospital is crowded already.

Further consideration of the possibilities of providing for chronically ill patients in separate wards or buildings may overcome many of these objections to the general hospital's supervising such care, and thus make responsibility for such care acceptable to more of the general hospitals. On the other hand, three-fourths of the administrators expressing themselves on this question favored having the general hospital care for the chronically ill, or at least certain types of chronic illness. However, a majority favored limiting the admission of these patients to hospitalization in separate buildings, wings or wards; admission only of specific types of cases or for those able to benefit from treatment; or admission for diagnostic or screening purposes only. See Table 25.

Those hospital administrators who did not favor admitting the chronically ill patients gave varying reasons for their opinions—the nature of the care needed, the psychological effect upon the acutely ill patients, the lack of nursing personnel, the demand for beds by the acutely ill.

"I do not think that the chronically ill should be cared for in the general hospital. The character of service and the course of treatment are such that the general attitude towards the patients' problems is not adjusted to the situation."—From letter of P. Godfrey Savage, Superintendent, Niagara Falls Memorial Hospital, March 30, 1945.

"From a psychological standpoint I do not think it is fair to the acutely ill to be admitted to wards where there are chronically ill patients. To admit chronically ill patients to a general hospital would also increase the cost to such patients."—From letter of Pearl A. Klick, Superintendent, North Country Community Hospital, Glen Cove, May 15, 1945.

"We have given the matter of hospitalization of the chronically ill considerable thought for we do feel that it is the place of the general hospital to take care of this type patient. However, at the present time, with the problem of insufficient nursing help, we are forced to say that provisions for taking care of the chronically ill should be made outside the general hospital, at least temporarily."—From letter of Mother M. Assunta, Superintendent, St. Francis Hospital, Inc., Olean, July 10, 1945.

"Our idea of a general hospital is that it is a place to take care of acutely ill patients until they are ready to be discharged to their own homes or to a convalescent home. We do not feel that such beds should be held by chronic cases nor that the services of student nurses or the graduate nursing staff in a general hospital should be used for their care."—From letter of Sister Mary Esther, Superintendent, St. Peter's Hospital, Albany, May 14, 1945.

TABLE 25. *Role of General Hospital in the Care of the Chronically Ill*

Reply to question: "What is your opinion with regard to the role that the general hospital should play in the care of the chronically ill?"		Hospitals
Total		139
Care of the chronically ill considered a responsibility of, or acceptable to, the general hospital		84
No restrictions mentioned	24	
Restrictions mentioned	60	
In separate wards, wings, units or buildings	40	
For certain cases or those who can benefit from treatment	10	
For physical work-up only	4	
If funds are provided to pay for it	1	
For those able to pay	1	
To act as filtering agent	2	
State operated hospitals attached to teaching hospitals	1	
Number of cases should be kept to a minimum	1	
Care of the chronically ill not considered a responsibility of, or not acceptable to, the general hospital		30
No reply to question		25

Conversely, other administrators were of the opinion that general hospitals should admit the chronically ill rather freely and, in their replies, indicated no restrictions that might limit eligibility for care.

"It would seem that there are two developments that have a bearing on this part of the subject:

"In the first place, the development of Blue Cross Plans has made the public hospital conscious, with the result that many cases that formerly would not have thought of entering a hospital are now being hospitalized.

"Secondly, the trend of housing is toward small units. This makes it impossible to care for an extended illness in the home for, in many cases, all the members of the household are working, leaving no one to take care of the patient.

"If accommodations for chronic cases can be provided in general hospitals, many of the present problems in caring for such cases would be solved. It would furnish accommodations that would always be available which, under present conditions, is many times a serious problem. It would make available medical and nursing care at all times together with facilities for proper control of diets."—From letter of M. E. Sawtelle, Assistant Superintendent, Binghamton City Hospital, May 10, 1945.

"I feel that the general hospital inevitably is facing the time when it must make suitable provision for the care of chronics. I would go even further and include in the future program of the general hospital the care of the mentally sick and the 'not quite' indigent aged. As I see it, these are the very definite problems and obligations of society. And society is beginning to look to the general hospital for help in their solution. Personally, I see no reason why provision for such cases cannot be included in the general hospital scheme."—From letter of Leonard A. Lubbock, Superintendent, Faxton Hospital, Utica, April 12, 1945.

"I believe that units for the care of such cases (the chronically ill) should be an integral part of a general hospital in order that the patients may get the advantage of adequate medical consultative service and the usual diagnostic services, and that medical and nursing services may be kept on an adequately high plane."—From letter of Arthur S. Moore, M. D., Superintendent, Elizabeth A. Horton Memorial Hospital, Middletown, April 18, 1945.

"In terms of its local community standing and relationships, the general hospital has a big stake. Under certain circumstances the average general hospital does care for a limited amount of chronic illness, although sometimes perhaps unwillingly. To fulfill its responsibility in the community which it serves, the determination of acceptability of the case or the patient's care at the hospital, when chronic illness has been diagnosed, should be in terms of something other than the individual's or his family's local community prestige, standing and financial resources. The public will be inceasingly intolerant of one standard of care for those suffering from acute illness, and a different one for the chronically ill—largely in terms of what 'hit or miss' provision the doctor, patient, hospital or community can work out."—From letter of E. L. Harmon, M. D., Director, Grasslands Hospital, Valhalla, June 26, 1945.

"From the standpoint of nursing education, it would seem important that the nurse-student receive experience in caring for this type of patient as well as the acutely ill. Probably this would be a good reason for having the general hospital (connected with a school of nursing) assume responsibility for the care of the chronically ill. It would appear that a good program of occupational therapy would be necessary for the chronic patient, although this may not be feasible in the small general hospital."—From letter of Sister Mary Rita, R.S.M., Mercy Hospital, Watertown, April 12, 1945.

Other hospital administrators visualize the general hospital primarily as a unit with which institutions for the chronically ill might affiliate and call upon for specialized services.

"Caring for the chronically ill is very difficult for us since we have a capacity of only 16 beds and eight bassinets. Since our work consists chiefly of obstetrical, emergency and a few medical and out-patient x-ray cases, we would find ourselves swamped in no time if we opened our doors to the large number of chronic cases which we always have with us, definitely placing us in the 'nursing home' class. However, it sems to me that many of these cases would respond in time with medical and skilled nursing care if a separate building were added just for these cases. It would render a great service to suffering humanity. It would also relieve our County Welfare Department of the headache of placements and great expense over a long period of time. I do find that, generally speaking, most nurses tire very quickly under this particular type of nursing so that it would seem wise

to rotate the nursing staff, provided there is no training school, to get the maximum amount of nursing with the least amount of fatigue. Somehow I always feel badly to have to turn these people away but, under the present setup, it is just impossible to give the proper care to our temporary sick people and cater to the chronic cases at the same time."—From letter of Mrs. Alice Thrane, Superintendent, Emma Laing Stevens Hospital, Granville, August 9, 1945.

"Care of the chronically ill should be a definite community responsibility of each hospital. Special separate facilities should be provided. Care and treatment should be as thorough as that given to other patients. Staff members, especially selected, should be responsible for medical care. When these patients are housed in hospitals instead of nursing, convalescent homes, etc., it is also an inducement for physicians to see them oftener, since they center their practice in hospitals."—From letter of J. Dewey Lutes, Superintendent, Yonkers General Hospital, May 21, 1945.

"While I realize that in the hospital field today, the trend is toward erecting hospitals for the chronically ill, I personally do not like the idea. In the first place, a hospital solely caring for 'chronic' patients would not have a good psychological effect on the patients. The very thought that the hospital is a 'chronic' hospital is depressing. It is 'deadly' for a nurse, too. She cannot bring a 'lift' to her patients when she is caring exclusively for 'chronics.' She must have more active cases to keep up her interest and give her 'the will to bring health' to her patients.

"The above is without doubt heresy *but solely for the good of the patient.* I would say that care should be given to chronic cases on an 'active' division (one chronic case, say, to ten actively ill or convalescent patients) or in a separate wing or floor of a general hospital. In the latter case, the nurses should be changed often, preferably assigned for not more than one week at a time and never more than two weeks on this service."—From letter of Harriet G. Moore, Superintendent, Park Avenue Hospital, Rochester, March 31, 1945.

"It seems quite clear that any institution for the chronically ill should have close geographic and professional association with a general hospital well equipped to deal with emergencies (which are frequent in the aged and chronically ill) and to take care of conditions requiring the attention of specialists."—From letter of G. M. Mackenzie, M. D., Physician-in-Chief, Mary Imogene Bassett Hospital, Cooperstown, June 4, 1945.

"The Cortland County Hospital, due to increased demand for general hospital care during 1946, has been unable to accommodate many persons who need convalescent care. A large number of post-operative, as well as other hospital patients, have occupied needed beds for longer periods than necessary due to the lack of other facilities for such convalescents.

"Included in the future program for expansion of our hospital facilities, is a separate suitable building, erected on the premises, for the care of chronically ill and convalescents.

"Such an addition seems imperative as our general hospital facilities are now operating at 90 per cent of bed capacity, which precludes the admission of many who should have such care."—From letter of D. N. Abbott, Administrator, Cortland County Hospital, December 19, 1946.

"You asked what my opinion was in regard to the role that the general hospitals should play in the care of the chronically ill. I believe that the general hospitals should care for these patients up until the time that they no longer need the kind of treatment that they receive as acutely ill patients. At the end of that period I believe that they could be better and more economically cared for either in a separate hospital or a separate wing or building of the general hospital. It would be most advisable for a hospital for the chronically ill to be under the same management or closely affiliated with a general hospital in order that these patients might have the benefit of the same quality of medical care and medical supervision. I think that much could be done for the long-term patients and they, as well as the acutely ill, should have the benefit of research and expert medical opinion."—From letter of Miriam Curtis, Superintendent, Syracuse Memorial Hospital, May 24, 1945.

CONCLUSIONS

The problems and opinions stated by the hospital administrators may, in some instances, reflect present conditions of increased demands for hospital facilities, generally improved economic conditions and personnel shortages. Although it is not possible to determine the extent to which this may be true, it would seem that the same over-all problems in providing for the chronically ill exist for the most part in "normal" times also, and are merely accentuated by present conditions. Difficulties in obtaining hospital and other institutional care for the chronically ill were known to exist long before the period of war-created shortages and, doubtless, will continue to exist after these shortages are over.

The great majority of the general hospitals reported that they admit chronically ill patients for care—some to a greater and some to a lesser extent; some because they feel that such patients can benefit from hospital care and others only because alternate facilities are not availible; and some because, even with personnel and bed shortage, they feel that such service is their social and medical responsibility.

There is a general consensus that, under existing circumstances of hospital arrangements and limitations, those chronically ill who can no longer profit from intensive hospital care should be transferrable to medically related institutions of the nursing home type when long-term institutional care is medically indicated. Unfortunately, such alternate facilities are generally unavailable in satisfactory quantity or quality, are often too expensive or are rejected by the patient or his relatives. This inability to stimulate a flow of patients to more appropriate places of care creates a "bottleneck," retards the admission of other chronically ill as well as acutely ill persons requiring hospitalization, and makes it impossible for the hospital to make available its special skills to the general public to the fullest extent.

The administrators had numerous suggestions not only for alleviating this situation, but also for improving the quality of care provided the chronically ill. They recommended new, expanded, improved, and better equipped and staffed hospital, nursing home and convalescent care facilities. The suggestion was frequently made that such nursing home, convalescent or medical domiciliary institutions should be affiliated with general hospitals. Some favored liberalized methods of payment for the indigent. Others advocated regulation of proprietary nursing homes. And still others expressed a desire to see nurses more adequately trained, out-patient clinics established and special diagnostic facilities and services made available for the chronically ill.

Although there was a general opinion that many of these improvements could be achieved by voluntary effort, a number of administrators felt that there was need also for stimulation by public leadership and funds, especially since prolonged illnesses deplete the financial reserves of most families and because private philanthropic funds are less available than formerly.

The majority of the general hospitals reported their willingness to care for the chronically ill, especially if separate wards, wings or units could be added to the present structures. On the other hand, they wished to be assured that, when their chronically ill patients could be more appropriately placed in nursing or medical domiciliary homes of high quality, such facilities would be available.

In brief, the hospitals are generally willing to do their share in providing timely and proper care for the chronically ill. They want to be certain that there will be no "bottlenecks" and that the needed auxiliary facilities and services will be available to receive patients on transfer. They are willing and eager to assume their proper responsibility in helping their communities meet the medical and social needs of the chronically ill.

APPENDIX

NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

292 Madison Avenue, New York 17, N. Y.

(Copy of Letter Sent to Administrators of General Hospitals)

March 27, 1945

Dear ————————:

The studies conducted by the Health Preparedness Commission have served to bring to light a number of problems in relation to provision for the care of the chronically ill in New York State. Accordingly, the Commission expects to give the matter further consideration.

While we will need to make use of certain facts, it is not our intention to go about this through the submission of detailed questionnaires or fact-finding procedures, except as may prove absolutely essential in a support of good policy formation. However, in view of the fact that the question of the care of chronic illness is of such great importance in the administration of a general hospital, I am presuming upon your interest to request from you a brief statement of your thinking in regard to it. It is my hope that statements from general hospital administrators as a group may prove of great usefulness to the Commission in formulating its ideas.

We are using a very broad working definition of chronic illness as being one of two to three months duration with an indefinite prognosis, or a disease of an irremediable nature. It would be most helpful for me to have advice from you, on the basis of your current experience and your estimates of the probable postwar needs and plans of your community, as to the following: (1) Approximately what proportion of beds in your institution are assigned to the care of individuals because of chronic illness? (2) Do you have satisfactory arrangements for referring chronically ill individuals who require further hospital care to institutions, i.e. suitable nursing homes, convalescent homes or similar institutions? (3) If there appear to be unmet needs for hospital, clinic, or other services for the medical care of these individuals in your community, what do you consider these needs to be? (4) What is your opinion with regard to the role that the general hospital should play in the care of the chronically ill?

I would appreciate any help that you can give me in this problem.

Sincerely yours,

(Signed) Lee B. Mailler,
Chairman

TABLE 26. *General Hospitals Replying to the Letter of Inquiry; With Supplemental Columns Indicating Approval by the American College of Surgeons, Auspices, Capacity, Average Daily Census, Per Cent Occupancy and Admissions; New York State, Exclusive of New York City, 1944* [1]

NAME OF HOSPITAL	LOCATION		Approved by American College of Surgeons [2]	Auspices	Bed Capacity	Average Daily Census	Per Cent Occupancy	Admissions
	Post Office	County						
Total (139 hospitals)					19,421	14,798	76.2	456,389
A. Barton Hepburn Hospital	Ogdensburg	St. Lawrence	App.	Church	160	145	90.6	3,987
Albany Hospital	Albany	Albany	App.	NPA	[3] 597	531	88.9	12,805
Albert Lindley Lee Memorial Hospital	Fulton	Oswego	Prov. App.	City	61	36	59.0	1,094
Amsterdam City Hospital	Amsterdam	Montgomery	Prov. App.	NPA	119	93	78.2	2,875
Arnold Gregory Memorial Hospital	Albion	Orleans	.....	NPA	24	18	75.0	771
Arnot-Ogden Memorial Hospital	Elmira	Chemung	Prov. App.	NPA	194	160	82.5	5,697
Aurelia Osborn Fox Memorial Hospital	Oneonta	Otsego	.....	NPA	74	61	82.4	2,167
Auburn City Hospital	Auburn	Cayuga	App.	NPA	215	181	84.2	6,198
Batavia Hospital (Genesee Memorial)	Batavia	Genesee	Prov. App.	NPA	65	52	80.0	1,791
Bath Memorial Hospital	Bath	Steuben	App.	NPA	60	40	66.7	1,667
Benedict Memorial Hospital	Ballston Spa	Saratoga	.....	NPA	25	14	56.0	606
Benedictine Hospital	Kingston	Ulster	App.	Church	90	80	88.9	3,182
Bethesda Hospital	Hornell	Steuben	App.	NPA	44	26	59.1	1,039
Binghamton City Hospital	Binghamton	Broome	App.	City	490	333	68.0	8,945
Brockport Central Hospital	Brockport	Monroe	.....	NPA	17	14	82.4	519
Buffalo General Hospital	Buffalo	Erie	App.	NPA	441	424	96.1	10,576
Buffalo Hospital of the Sisters of Charity	Buffalo	Erie	App.	Church	215	166	77.2	5,774
Canastota Memorial Hospital	Canastota	Madison	.....	City	21	13	61.9	570
Champlain Valley Hospital	Plattsburgh	Clinton	App.	NPA	106	79	74.5	3,354
Charles S. Wilson Memorial Hospital	Johnson City	Broome	App.	NPA	318	221	69.5	6,540
Chenango Memorial Hospital	Norwich	Chenango	Prov. App.	NPA	76	52	88.4	1,632
City Hospital	Salamanca	Cattaraugus	.....	City	46	35	76.1	2,073
Clifton Springs Sanitarium and Clinic	Clifton Springs	Ontario	App.	NPA	275	144	52.4	3,620
Cohoes Hospital	Cohoes	Albany	Prov. App.	NPA	69	45	65.2	1,223
Community Hospital	Chatham	Columbia	.....	Ind.	35	14	40.0	254
Corning Hospital	Corning	Steuben	App.	NPA	105	57	54.3	3,889
Cornwall Hospital	Cornwall	Orange	App.	NPA	66	40	60.6	1,321
Cortland County Hospital	Cortland	Cortland	Prov. App.	NPA	128	88	68.8	2,963
Crouse-Irving Hospital	Syracuse	Onondaga	App.	NPA	215	201	93.5	7,250
Cuba Memorial Hospital	Cuba	Allegany	Prov. App.	NPA	25	18	72.0	788
Dansville General Hospital	Dansville	Livingston	Prov. App.	NPA	42	21	50.0	1,015
Deaconess Hospital	Buffalo	Erie	App.	NPA	190	168	88.4	5,984
Delhi Hospital	Delhi	Delaware	.....	NPA	16	9	56.3	418
Dobbs Ferry Hospital	Dobbs Ferry	Westchester	.....	NPA	46	29	63.0	918
Doctor King's Hospital	Bay Shore	Suffolk	.....	Ind.	34	12	35.3	528
Edward J. Meyer Memorial Hospital	Buffalo	Erie	App.	City	[3] 1,131	790	69.8	9,101
Elizabeth A. Horton Memorial Hospital	Middletown	Orange	App.	NPA	90	93	103.3	2,760
Ellis Hospital	Schenectady	Schenectady	App.	NPA	400	306	76.5	12,742
Emergency Hospital (Sisters of Charity)	Buffalo	Erie	App.	Church	168	137	81.5	4,956
Emma Laing Stevens Hospital	Granville	Washington	.....	NPA	16	10	62.5	299
Faxton Hospital	Utica	Oneida	Prov. App.	NPA	106	100	94.3	4,422
Frederick Ferris Thompson Hospital	Canandaigua	Ontario	App.	Corp.	124	66	53.2	2,096
General Hospital	Utica	Oneida	Prov. App.	City	128	40	31.3	2,572
General Hospital of Saranac Lake	Saranac Lake	Franklin	App.	NPA	50	36	72.0	1,046
General Hospital of Syracuse	Syracuse	Onondaga	App.	NPA	127	107	84.2	3,309
Genesee Hospital	Rochester	Monroe	App.	NPA	226	185	81.8	6,252
Geneva General Hospital	Geneva	Ontario	App.	NPA	98	78	79.6	2,510
Glens Falls Hospital	Glens Falls	Warren	Prov. App.	NPA	120	113	94.2	3,971
Good Samaritan Hospital	Suffern	Rockland	App.	Church	92	69	75.0	2,528
Grasslands Hospital	Valhalla	Westchester	App.	County	[4] 810	591	73.0	4,465
Herkimer Memorial Hospital	Herkimer	Herkimer	.....	NPA	52	47	90.4	1,713
Highland Hospital	Rochester	Monroe	App.	NPA	195	157	80.5	5,273
Hospital of the Good Shepherd	Syracuse	Onondaga	App.	NPA	195	149	76.4	4,287
House of the Good Samaritan	Watertown	Jefferson	App.	NPA	160	133	83.1	3,773
Hudson City Hospital	Hudson	Columbia	App.	NPA	100	91	91.0	4,047
Huntington Hospital Association	Huntington	Suffolk	App.	NPA	75	64	85.3	2,728
Ideal Hospital	Endicott	Broome	App.	City	96	59	61.4	2,505
Ilion Hospital	Ilion	Herkimer	.....	NPA	62	46	74.2	2,495
Jamestown General Hospital	Jamestown	Chautauqua	App.	City	116	89	76.7	3,188
Jefferson Hospital	Schoharie	Schoharie	.....	Ind.	8	4	50.0	110
John T. Mather Memorial Hospital	Port Jefferson	Suffolk	App.	NPA	70	49	70.0	2,489
Kingston Hospital	Kingston	Ulster	App.	NPA	108	70	64.8	2,510
Lafayette General Hospital	Buffalo	Erie	.....	NPA	64	41	64.1	1,801
Lawrence Hospital	Bronxville	Westchester	App.	NPA	104	75	72.1	2,631
Leonard Hospital	Troy	Rensselaer	Prov. App.	NPA	125	106	84.8	3,329
Lewis County General Hospital	Lowville	Lewis	Prov. App.	State-Co.	44	32	72.7	1,062
Little Falls Hospital	Little Falls	Herkimer	Prov. App.	NPA	76	45	59.2	1,786
Lyons Hospital	Lyons	Wayne	.....	Corp.	26	11	42.3	437
Mary Imogene Bassett Hospital	Cooperstown	Otsego	App.	NPA	95	56	58.9	1,833
Mary McClellan Hospital	Cambridge	Washington	App.	NPA	100	59	59.0	992
Meadowbrook Hospital	Hempstead	Nassau	App.	County	250	205	82.0	4,770
Medina Memorial Hospital	Medina	Orleans	App.	NPA	38	30	78.9	1,049
Memorial Hospital	Albany	Albany	App.	NPA	130	117	90.0	3,407
Memorial Hospital	Wellsville	Allegany	Prov. App.	City	55	42	76.4	1,823
Memorial Hospital of Greene County	Catskill	Greene	Prov. App.	State-Co.	70	59	84.3	1,840

TABLE 26. *General Hospitals Replying to the Letter of Inquiry; With Supplemental Columns Indicating Approval by the American College of Surgeons, Auspices, Capacity, Average Daily Census, Per Cent Occupancy and Admissions; New York State, Exclusive of New York City, 1944* [1] — (Concluded)

NAME OF HOSPITAL	LOCATION		Approved by American College of Surgeons [2]	Auspices	Bed Capacity	Average Daily Census	Per Cent Occupancy	Admissions
	Post Office	County						
Mercy General Hospital	Tupper Lake	Franklin	.....	Church	30	19	63.3	536
Mercy Hospital	Auburn	Cayuga	Prov. App.	Church	84	75	89.3	2,634
Mercy Hospital	Buffalo	Erie	App.	Church	198	166	83.8	6,127
Mercy Hospital	Watertown	Jefferson	App.	Church	139	133	95.7	3,773
Millard Fillmore Hospital	Buffalo	Erie	App.	NPA	337	322	95.5	11,822
Mineville Hospital	Mineville	Essex	App.	NPA	18	11	61.1	1,012
Monroe County Hospital	Rochester	Monroe	App.	County	500	430	86.0	2,088
Monticello Hospital	Monticello	Sullivan	.....	NPA	26	15	57.7	709
Moses Ludington Hospital	Ticonderoga	Essex	App.	Corp.	47	28	59.6	1,012
Nassau Hospital	Mineola	Nassau	App.	NPA	227	174	76.6	6,124
Nassau-Suffolk General Hospital	Copiague	Suffolk	.....	Ind.	45	32	71.1	1,608
Nathan Littauer Hospital	Gloversville	Fulton	Prov. App.	NPA	133	110	82.7	4,881
New Rochelle Hospital	New Rochelle	Westchester	App.	NPA	264	217	82.2	7,034
Niagara Falls Memorial Hospital	Niagara Falls	Niagara	App.	NPA	165	153	92.7	5,194
North Country Community Hospital	Glen Cove	Nassau	App.	NPA	100	75	75.0	2,936
Northern Dutchess Health Service Center	Rhinebeck	Dutchess	App.	NPA	35	34	97.1	812
Northern Westchester Hospital	Mt. Kisco	Westchester	App.	NPA	108	88	81.5	2,771
Oneida City Hospital	Oneida	Madison	App.	City	80	61	76.2	2,621
Ossining Hospital	Ossining	Westchester	App.	NPA	65	54	81.8	2,002
Our Lady of Victory Hospital	Lackawanna	Erie	App.	Church	148	106	71.6	3,915
Park Avenue Hospital	Rochester	Monroe	App.	NPA	92	85	92.4	3,465
Parshall Private Hospital	Oneonta	Otsego	.....	Ind.	28	5	17.8	175
Physicians Hospital of Plattsburgh	Plattsburgh	Clinton	App.	NPA	85	70	82.4	2,622
Potsdam Hospital	Potsdam	St. Lawrence	App.	NPA	70	67	95.7	2,344
Rochester General Hospital	Rochester	Monroe	App.	NPA	322	249	77.3	9,373
St. Agnes Hospital	White Plains	Westchester	Prov. App.	Church	138	80	58.0	2,695
St. Anthony's Hospital	Warwick	Orange	Prov. App.	Church	50	17	34.0	640
St. Elizabeth Hospital	Utica	Oneida	App.	Church	140	145	103.6	5,661
St. Francis Hospital	Olean	Cattaraugus	Prov. App.	Church	100	52	52.0	1,641
St. Francis Hospital	Port Jervis	Orange	App.	Church	55	34	61.8	1,067
St. Francis Hospital	Poughkeepsie	Dutchess	App.	Church	104	79	76.0	2,221
St. James Mercy Hospital	Hornell	Steuben	App.	Church	102	60	58.8	3,723
St. Jerome Hospital	Batavia	Genesee	App.	Church	73	62	84.9	2,521
St. Joseph's Hospital	Syracuse	Onondaga	App.	Church	200	157	78.5	5,031
St. Joseph's Hospital	Yonkers	Westchester	App.	Church	177	101	57.1	2,553
St. Luke's Home and Hospital	Utica	Oneida	App.	Church	123	92	74.8	3,192
St. Luke's Hospital [5]	Newburgh	Orange	App.	NPA	188	130	69.1	4,110
St. Mary's Hospital	Amsterdam	Montgomery	Prov. App.	Church	120	100	83.3	2,818
St. Mary's Hospital	Rochester	Monroe	App.	Church	325	273	84.0	8,313
St. Peter's Hospital	Albany	Albany	App.	Church	159	130	81.8	4,468
Samaritan Hospital	Troy	Rensselaer	Prov. App.	NPA	181	143	79.0	4,559
Saratoga Hospital	Saratoga Springs	Saratoga	App.	NPA	90	57	63.3	2,106
Seneca Falls Hospital	Seneca Falls	Seneca	App.	City	30	18	60.0	629
Soldiers and Sailors Memorial Hospital	Penn Yan	Yates	Prov. App.	NPA	50	29	58.0	1,120
South Nassau Communities Hospital	Rockville Centre	Nassau	App.	NPA	100	96	96.0	4,127
Southampton Hospital Association	Southampton	Suffolk	App.	NPA	100	47	47.0	1,854
Strong Memorial-Rochester Municipal Hospital	Rochester	Monroe	App.	NPA-City	649	460	70.9	14,357
Syracuse Memorial Hospital	Syracuse	Onondaga	App.	NPA	270	212	78.5	6,744
Tarrytown Hospital Association	Tarrytown-on-Hudson	Westchester	App.	NPA	57	38	66.7	1,706
Tompkins County Memorial Hospital	Ithaca	Tompkins	Prov. App.	NPA	147	91	61.9	3,325
Townsend Hospital	Gowanda	Cattaraugus	.....	NPA	22	16	72.7	790
Troy Hospital	Troy	Rensselaer	Prov. App.	Church	272	147	54.0	4,078
Tuxedo Memorial Hospital	Tuxedo	Orange	App.	NPA	33	17	51.5	543
United Hospital	Port Chester	Westchester	App.	NPA	196	130	66.3	4,863
Utica Memorial Hospital	Utica	Oneida	Prov. App.	NPA	76	61	80.3	3,150
Vassar Brothers Hospital	Poughkeepsie	Dutchess	App.	NPA	207	175	84.5	5,490
Veterans Memorial Hospital	Ellenville	Ulster	.....	NPA	18	11	61.1	504
Waterloo Memorial Hospital	Waterloo	Seneca	.....	NPA	25	20	80.0	548
Wayland Hospital	Wayland	Steuben	.....	Ind.	17	12	70.6	512
White Plains Hospital	White Plains	Westchester	App.	NPA	178	139	78.1	5,199
Women's Christian Association Hospital	Jamestown	Chautauqua	App.	NPA	110	109	99.1	3,974
Wyoming County Community Hospital	Warsaw	Wyoming	App.	State-Co.	122	100	82.0	2,581
Yonkers General Hospital	Yonkers	Westchester	App.	NPA	142	112	78.9	3,830
Yonkers Professional Hospital	Yonkers	Westchester	.....	Corp.	125	90	72.0	2,616

Abbreviations:
App.— approved
Prov. App.— provisional approval
Co. — county
Corp.— corporation
Ind. — individual
NPA — non-profit association

[1] Inquiry was addressed *only* to those general hospitals registered by the American Medical Association for 1944. Detailed data adapted from *Journal of the American Medical Association* (Hospital Number), Vol. 127, No. 13, March 31, 1945. *Bulletin of American College of Surgeons* (Approval Number), Vol. 29, No. 4 Dec. 1944.

[2] It should be noted that the American College of Surgeons does not customarily consider for approval those hospitals with capacities under 25 beds.

[3] Includes beds specifically assigned to tuberculosis service.

[4] Includes beds specifically assigned to tuberculosis and psychiatric service.

[5] Although approved by the American College of Surgeons, St. Luke's Hospital was not registered by the American Medical Association for 1944. It was included in the inquiry, however, because of the large volume of service provided patients in the locality of the hospital.

TABLE 27. *General Hospitals Not Replying to the Letter of Inquiry; With Supplemental Columns Indicating Approval by the American College of Surgeons, Auspices, Capacity, Average Daily Census, Per Cent Occupancy and Admissions: New York State, Exclusive of New York City, 1944* [1]

NAME OF HOSPITAL	LOCATION		Approved by American College of Surgeons [2]	Auspices	Bed Capacity	Average Daily Census	Per Cent Occupancy	Admissions
	Post Office	County						
Total (41 hospitals)					[3] 2,734	[4] 1,814	[4] 66.3	[4] 66,562
Alice Hyde Memorial Hospital	Malone	Franklin	Prov. App.	NPA	82	70	85.4	1,912
Bathgate Hospital	Stanford	Delaware	.....	NPA	17	8	47.1	446
Brooks Memorial Hospital	Dunkirk	Chautauqua	.....	NPA	114	65	57.0	2,913
Buffalo Columbus Hospital	Buffalo	Erie	.....	NPA	140	89	63.6	2,638
Callicoon Hospital	Callicoon	Sullivan	.....	Ind.	13	9	69.2	331
Corinth Hospital	Corinth	Saratoga	.....	NPA	16	NR	..	NR
De Graff Memorial Hospital	North Tonawanda	Niagara	.....	City	55	50	90.9	3,880
Eastern Long Island Hospital	Greenport	Suffolk	.....	NPA	47	30	63.8	1,254
Edward J. Barber Hospital	Lyons	Wayne	.....	Ind.	22	16	72.7	610
Elizabethtown Community Hospital	Elizabethtown	Essex	.....	NPA	15	8	53.3	151
Genesee Country Memorial Hospital	Fillmore	Allegany	.....	NPA	14	4	28.6	147
Goshen Hospital	Goshen	Orange	Prov. App.	NPA	40	27	67.5	865
Hamilton Avenue Hospital	Monticello	Sullivan	.....	Ind.	21	16	76.2	468
Highland Hospital	Beacon	Dutchess	.....	NPA	50	29	58.0	1,013
J. F. Meyers Hospital	Sodus	Wayne	.....	Ind.	25	14	56.0	379
Julia L. Butterfield Memorial Hospital	Cold Spring	Putnam	.....	NPA	45	20	44.4	499
Lake Placid General Hospital	Lake Placid	Essex	Prov. App.	City	20	11	55.0	337
Lockport City Hospital	Lockport	Niagara	.....	City	142	107	75.4	4,018
Long Beach Hospital	Long Beach	Nassau	Prov. App.	NPA	60	31	51.7	1,152
Maimonides Lodge Hospital	Liberty	Sullivan	.....	NPA	39	23	59.0	690
Main Street Hospital	Oneida	Madison	.....	Ind.	16	13	81.2	328
Margaretville Hospital	Margaretville	Delaware	.....	NPA	32	19	59.4	809
Middletown Sanitarium and Hospital	Middletown	Orange	.....	Ind.	50	NR	...	NR
Mountain Clinic	Olean	Cattaraugus	.....	Ind.	33	18	54.5	625
Mt. St. Mary's Hospital	Niagara Falls	Niagara	.....	Church	188	152	80.8	5,576
Mt. Vernon Hospital	Mt. Vernon	Westchester	App.	NPA	213	128	60.1	4,975
Newark Hospital	Newark	Wayne	.....	Ind.	26	22	84.6	678
Nyack Hospital	Nyack	Rockland	App.	Corp.	91	73	80.2	2,222
Olean General Hospital	Olean	Cattaraugus	Prov. App.	NPA	85	64	75.3	2,344
Onondaga General Hospital	Syracuse	Onondaga	.....	NPA	65	NR	....	NR
Oswego Hospital	Oswego	Oswego	.....	NPA	89	70	78.6	2,237
Our Lady of Lourdes Memorial Hospital	Binghamton	Broome	App.	Church	88	64	72.7	2,337
Peekskill Hospital	Peekskill	Westchester	Prov. App.	NPA	77	34	44.2	1,932
People's Hospital	Syracuse	Onondaga	.....	NPA	28	16	57.1	578
Rome Hospital and Murphy Memorial Hospital	Rome	Oneida	App.	City	83	72	86.7	3,067
St. John's Riverside Hospital	Yonkers	Westchester	App.	NPA	188	126	67.0	4,429
St. Joseph's Hospital	Elmira	Chemung	Prov. App.	Church	242	188	77.7	5,595
Shepard Relief Hospital	Montour Falls	Schuyler	.....	NPA	36	23	63.4	758
Southside Hospital	Bay Shore	Suffolk	App.	NPA	90	75	83.3	3,266
Stephen B. Van Duzee Hospital	Gouverneur	St. Lawrence	App.	NPA	22	15	68.2	655
Ver Nooy Sanitarium	Cortland	Cortland	.....	Ind.	15	15	100.0	448

Abbreviations:
App.— approved
Prov. App.— provisional approval
Corp.— corporation
Ind. — individual
NPA — non-profit association
NR — no report (in Journal of American Hospital Association)

[1] Inquiry was addressed *only* to those general hospitals registered by the American Medical Association for 1944. Detailed data adapted from *Journal of the American Medical Association* (Hospital Number), Vol. 127, No. 13, March 31, 1945; *Bulletin of American College of Surgeons* (Approval Number), Vol. 29, No. 4, Dec. 1944.

[2] It should be noted that the American College of Surgeons does not customarily consider for approval those hospitals with capacities under 25 beds.

[3] Includes three hospitals whose average daily census and admissions are not reported, i.e. Corinth Hospital (16 beds), Middletown Sanitarium and Hospital (50 beds) and Onondaga General Hospital (65 beds).

[4] Exclusive of Corinth Hospital, Middletown Sanitarium and Hospital, and Onondaga General Hospital.

OFFICIAL PLANNING IN OTHER STATES FOR THE CARE OF THE CHRONICALLY ILL—MAY, 1946*

INTRODUCTION

Individuals and welfare organizations have long been conscious of the need for adequate care for the chronically ill and have promoted programs to meet this demand. Their efforts were usually isolated, modest in volume and confined to a particular locality. In some populous urban areas private philanthropy years ago established convalescent homes for children requiring long-term nursing care, and alert boards of managers of non-public homes for the aged began converting their facilities to provide improved care for adults requiring protracted medical and nursing service but not hospitalization.

Interest in the chronically ill is now widespread and concerted. The problem is better understood by the public and pressure is being exerted upon government to "do something about it." Many factors have contributed to this demand: the rapidly increasing proportion of the aged in the general population; the fact that 50 of every 100 deaths today are caused by chronic disease as compared with six of every 100 seventy-five years ago; the National Health Survey findings that half the chronically ill are under 45 years of age, in the most productive age group; the realization that long illnesses impair productivity and social usefulness which are reflected eventually in less goods and services and increased medical-social problems; the demand for hospitalization of the chronically ill at a time when bed shortages necessitated rejection of acute cases; the mushroom growth of nursing homes and the apprehension of attending physicians and welfare officials relative to the poor quality of care often provided therein; the rising incidence of chronic disease, bringing to many families firsthand experience in dealing with this problem; the increasing proportion of aged and mentally and physically handicapped among recipients of public assistance, concurrent with the knowledge that chronic illness is more frequent in the relief and lower income groups than in the general population; the general acceptance of welfare services as a responsibility of government; the growing awareness of physicians and organized medicine of the magnitude of the problem, and the emergence of the specialties of geriatrics and gerontology; the layman's awareness of new medical discoveries; the tendency to make government responsible for new services as well as for many of those previously supported by private philanthropy or purchased by individuals on a fee basis.

Demands for public action have been variously expressed. For example: Qualified persons, testifying before a Senate Committee in 1944 on the need for an investigation of the physical fitness of the civilian population, frequently cited chronic illness as a scourge depleting the efficiency of our manpower and requiring preventive and ameliorative measures.[1] Similarly, witnesses appearing before the same Committee in 1945 to testify on the Hospital Construction Act urged the construction of proper facilities for the care of the chronically ill.[2]

It is significant that the American Public Welfare Association, in considering granting public assistance to inmates of public institutions (including public homes and infirmaries), authorized its Welfare Policy Committee and its Medical Care Committee to study this problem jointly. Drawing the latter Committee into these deliberations is mute testimony that the Association was of the opinion that care in public institutions included major medical care problems. This conclusion seems justified for, in the subsequent study made jointly by these Committees, the following conclusions were stated in summarizing the detailed facts:

> "There is need for institutional care of hospital type for the chronically ill who require constant medical care for diagnosis and treatment and who require long time skilled nursing care. There is need for custodial care for the physically incapacitated and mentally infirm who do not require care in mental hospitals. There is need for institutional care for children requiring special care and treatment under prolonged professional observation and supervision, and for some other groups of children."[3]

The foregoing are expressions in national forums. The same currents are running in some of our states, in their legislatures and their commissions—closer to where public officials must respond to demands, closer to where the chronically ill live and must be cared for, closer to where detailed planning for their care must take place. Planning on a state level has reached the definitive, formalized state in Connecticut, Illinois, Indiana, Maryland and Massachusetts and, although New Jersey does not have an official comprehensive plan, it has developed services for the chronically ill which are widely recognized and commended.

The existing or proposed plans of these states are summarized in the following pages, along with their respective programs for the control of alcoholism, wherever such exist.

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* This material was previously published in mimeographed form by the Commission in May, 1946.

[1] U. S. Congress, Senate, *Wartime Health and Education*, Hearings before Subcommittee of the Committee on Education and Labor, U. S. Senate, 78th Cong., 2nd Sess. (Part 5), on S. Res. 74, December 14, 15 and 16, 1944 (Washington: Government Printing Office, 1945). (Especially pp. 1850–1852.)

[2] U. S. Congress, Senate, *Hospital Construction Act*, Hearings before Committee on Education and Labor, U. S. Senate, 79th Cong., 1st Sess., on S. 191, February 26, 27, 28, March 12, 13 and 14, 1945 (Washington: Government Printing Office, 1945). (Especially pp. 364–365.)

[3] Louis Evans, "Providing Institutional Care for Recipients of Public Assistance," *Public Welfare* III (November, 1945), p. 253.

CONNECTICUT

Interest in chronic illness in Connecticut has arisen from a desire to provide improved care for the dependent chronically ill and for alcoholics of all economic strata. It is a humanitarian effort to make adequate medical care available to persons with long-term illnesses as well as an attempt to conserve the economic productivity and social usefulness of a larger segment of the population.

Purpose In accordance with an act of the 1943 State Legislature, the Public Welfare Council of Connecticut collected data and made recommendations relative to the need for a State Infirmary for the care and treatment of aged, infirm and chronically ill persons.[4] This summary is based upon the subsequently published report of the Council to the 1945 General Assembly.[5]

The information sought was designed to answer such practical questions as the following:

"1. How many Connecticut residents are incapacitated or prevented from leading productive self-sufficient lives because of prolonged illness or physical debility?
"2. What specific disorders or illnesses are responsible for this situation?
"3. What kind of care are these persons getting?
"4. What kind of care do they need?
"5. How many of these persons are dependent partially or wholly upon public assistance?
"6. What is the cost to taxpayers of this assistance?
"7. How much would it cost to give proper treatment and care to these persons?
"8. Could the provision of care *now* prevent certain persons from becoming permanently disabled and dependent upon public assistance later?
"9. Would a medical care program for these persons mean a reduction in public welfare and other costs?"[6]

Findings Chronic illness was defined as "a disease or condition of the body or personality which has been present at least six months or which may be expected to continue six months, and which interferes with one's occupation and normal physical and social life."[7]

The study estimated that in January 1944 there were at least 90,000 individuals in the State suffering from chronic disease: 20,000 adults dependent partially or wholly upon public assistance; 13,000 patients in State hospitals or institutions for the mentally ill, mentally defective, tubercular, blind and deaf; 6,000 dependent children; and an estimated 50,000 additional residents not dependent upon the agencies cooperating in the study. Since the survey was made at a time of high wartime economic activity, it was noted that some of the 50,000 non-dependent individuals might become public assistance recipients in the postwar years.

As the legislative instructions were concerned with the adult dependent population, exclusive of those in State institutions, the definitive findings of the study are generally confined to the 20,000 chronically ill dependent adults. The data present a detailed geographical distribution of the cases, thus providing a factual basis for the planning of facilities at locations accessible to potential patients.

In January 1944 roughly 40,000 of the population (2.5%) were receiving public assistance and the 20,000 chronically ill are, therefore, about half of this group. Three-quarters of the latter were 65 years old and over.

Since chronic illness and aging are interrelated, it was difficult to separate the older patients into one or the other of these two groups. The most prevalent diagnosis, as taken from records, were heart disease, arthritis and rheumatism, paralysis, blindness, diseases of the eyes and ears, senility and cancer. Actually, almost two-thirds of the 20,000 persons were suffering from two or more chronic ailments. Of every 100 adults, 56 were ambulatory, 33 partially ambulatory and 11 bedridden.[8] About two-thirds were living apart from their families—living alone (2,900) living away from their relatives or own homes (7,300), being cared for in hospitals (1,500) or in public homes (1,300).

Practically all the 20,000 adults were recipients of public assistance, the majority receiving over $8.00 per week. Some grants were higher, especially those to cancer cases, and some lower, particularly those to old age and senile deterioration cases.

Although including no evaluation of the quality of medical care provided for all the 20,000 chronically ill adults, the study states that 58% of the bedridden cases "are now getting a certain amount of medical care, although it may not be assumed to be adequate in all cases. According to the records analyzed, 11% (of the bedridden cases) get neither nursing nor medical care."[9]

Recommendations In formulating its recommendations, the Public Welfare Council recognized the need for improved and more adequate care for the dependent chronically ill, stressed the advisability of encouraging care of patients in their own homes whenever possible, advocated the proper geographical placement of future facilities to insure accessibility to the patients and emphasized the need for research and preventive measures.

In discussing the interrelationship of institutional and non-institutional care, the report of the Council states:

[4] *Special Acts of 1943, State of Connecticut*, Sec. 470, Approved June 30, 1943.
[5] Public Welfare Council, State of Connecticut, *Need for a State Infirmary for the Care and Treatment of Aged, Infirm and Chronically Ill Persons* (Hartford, 1944).
[6] *Ibid.*, p. 1.
[7] *Ibid.*, p. 4.
[8] *Ibid.*, p. 17. "A person was called partially ambulatory if he needed crutches or a cane in walking, or was so disabled that he was confined indoors." Bedridden patients were those confined to bed or wheelchair.
[9] *Ibid.*, p. 17.

"Although the first impression given by the foregoing data on the chronically ill is that hospitals and infirmaries are badly needed for their care, careful consideration should be given to all aspects of the problem and to the long range goals of government. It is practically axiomatic, of course, that every encouragement should be given to personal independence and self-support, rather than to social and economic dependence.

"It should also be axiomatic that a healthy citizenry is necessary to achieve any goal of self-sufficiency. It is probably much nearer the truth that people become dependent through chronic physical and mental disorders than that they become ill as a result of economic dependence.

"It would be possible for state institutions to be built to house and care for all dependent chronically ill, but a more acceptable social philosophy would hold that such institutions are really signs of failure to prevent the disorders that necessitated institutionalization. Therefore, consideration should be given to the questions of providing adequate medical care in the home, or home community, with the institution as the last resort or facility for such care as cannot be provided otherwise.

"Such consideration of the problem suggests four levels of medical care for the chronically ill:

(1) home care by local physicians and public health nurses,

(2) out-patient clinic consultation and treatments for the ambulatory,

(3) long term infirmary care, and

(4) chronic disease hospital treatment.

All four levels should be integrated for most efficient operation and for the benefit of the patient."[10]

On the basis of conclusions drawn from the factual data and the formulation of a general philosophy of public responsibility for care of the dependent chronically ill, the Public Welfare Council made three major recommendations relative to the care of the chronically ill, as follows:

1. Administration. The 1945 General Assembly should establish a board or commission to develop, over a period of several years, the suggested program for the care of the dependent chronically ill—build the facilities; establish and operate the services; coordinate the various aspects of the program; function as the administrative agency; and make provision for research into the causes, methods of prevention and treatment of chronic disease.

2. Building Program. The facilities required in order of need are: (a) infirmary beds, (b) State boarding homes for the aged and (c) hospital beds.

Five infirmaries should be constructed in different parts of the State with an aggregate minimum capacity of 3,000 beds. The architectural plans and placement on the terrain should be so conceived as to allow for future expansion by the addition of wings and without duplicating basic facilities. Each should be adequately staffed by qualified graduate nurses, trained attendants, a dietician, an occupational therapist and food service and maintenance personnel; each should have a consultant staff of medical specialists; and the group of infirmaries should share medical, psychiatric and psychological personnel employed by the commission on a full-time basis.

It was similarly recommended that five regional boarding homes for the aged with a total of 1,000 beds should be built, each to include suites for married couples. Each should have a graduate nurse, a dietician, an occupational therapist, and food service and maintenance staff. Medical care should be provided by a local physician on call and periodic examinations by the staff of the commission.

The establishment of 1,000 hospital beds was recommended for the observation, diagnosis and intensive medical treatment of chronically ill patients by medical specialists when such care cannot be provided satisfactorily or economically in one of the regional infirmaries. These beds might be provided in properly located, existing general hospitals meeting the prescribed standards of the commission, or in new State hospitals built for the purpose. The Public Welfare Council did not indicate a preference between these two methods, stating that such policy should be determined cooperatively by medical and governmental authorities on the basis of the nature of the problem, costs, needs and geographical location.

3. Non-Institutional Services. Public health nursing service, supplemented by housekeeper service, should be provided in order to encourage the care of patients in their own homes; and should be financed by the payment of standard fees per visit from public assistance funds to public health nursing organizations, rather than by establishing a State home nursing service.

For the same reason the report advocated the establishment of out-patient clinics in the general hospitals of the State, in State hospitals and in the infirmaries to provide diagnostic service, consultative service and limited treatment for the ambulatory chronically ill. This service is envisioned as encouraging home medical care, preventing institutionalization of some cases and providing care where patients are concentrated. The clinics should be staffed by personnel from the respective institutions and the professional staff of the commission.

4. Facilities for Chronic Alcoholics. Although the formal recommendations of the Public Welfare Council did not note the need for facilities for chronic alcoholics, a section of the report referred to this problem as follows: "Some type of institutional or colony care is needed for a large group of permanently disabled and incurable chronic alcoholics who would not benefit either from the nursing care in the infirmaries or the type of boarding home described above.

These persons are now resident in town farms, jails and mental hospitals. This proposal is, of course, only a temporary makeshift, considering the huge problem presented by the chronic alcoholic and vagrant group. It is recommended, therefore, that an extensive study be made of the problem of chronic alcoholism and drug addiction under instruction to report to the 1947 General Assembly."[11]

In this connection it should be noted that the 1945 Legislature created a commission to provide services to alcoholics, the details of which are described on page 77.

[10] *Ibid.*, p. 36.

[11] *Ibid.*, p. 44.

Costs The Public Welfare Council is convinced that the State is able to construct, operate and coordinate the proposed facilities and services more economically and can provide a higher quality of care than other units of government. However, the financial responsibility for the care of the individual patient will remain unchanged, the towns and the State paying their respective shares as now.

In the abstract of its report on the needs of the dependent chronically ill made to the 1945 General Assembly and to the Governor, the Public Welfare Council estimated the capital and operational costs of the proposed program. In doing so, it noted the impossibility of providing accurate estimates because of the fluctuation of costs of labor and material and the possibility of Federal aid.[12]

Building Program

Infirmaries (3,000 beds in 5 units)	$3,300,000
Boarding homes for the aged (1,000 beds in 5 units)	1,000,000
Hospital beds (1,000)	2,000,000
Total capital cost	$6,300,000

Annual Operating Costs

Commission administration and staff	$100,000
Infirmaries (3,000 beds)	1,800,000
Boarding homes for the aged (1,000 beds)	500,000
Hospital beds (1,000)	1,250,000
Home nursing and housekeeper service	250,000
Out-patient clinics	100,000
Research and training	100,000
Total gross annual cost	$4,100,000
Estimated present public expenditure for same patients	3,200,000
Total gross additional annual cost	$900,000

These operating costs do not include estimated income from patients, the receipt of which would lower the $900,000 gross annual cost.

Action Taken In 1945 the General Assembly passed and the Governor approved legislation establishing the Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm, as proposed in the report of the Public Welfare Council. This Commission is composed of five members appointed by the Governor, serving on rotating four-year terms, and including the State commissioners of health and welfare ex-officio. The Commission is to study the problems of the chronically ill, initiate a program for their care, coordinate and develop existing resources, establish and operate needed facilities and services and report biennially to the General Assembly and the Governor.[13]

The sum of $25,000 was appropriated "for the purpose of activating the most urgently needed components of the Commission's program." In this connection, it should be noted that the original bill carried an appropriation of $1,000,000 which was reduced to $25,000 by the Appropriations Committee of the General Assembly.

Control of Alcoholism In addition to the foregoing plan for the care of the medically indigent chronically ill, the Connecticut Legislature of 1945 recognized alcoholism as a public health problem and created a Board of Trustees of the State Fund for Inebriates, known as the Commission on Alcoholism.[14] "The basic purpose of the Commission is, through the use of clinics and other facilities, to provide diagnostic and treatment services for alcoholics, to study the problem of alcoholism and to disseminate information on this subject. Nine per cent of the fees for permits received by the Liquor Control Commission will be used annually to support the Commission."[15] It is estimated that this will make $200,000 to $225,000 available to the Commission each year.

In commenting on this legislation, Doctor Seldon D. Bacon, Chairman of the Commission, has listed the following as some of the more important principles stated or implied in the law:

"It recognizes that alcoholics are sick people.

"It recognizes the fact that alcoholics can be rehabilitated.

"It recognizes a responsibility on the part of the government to meet this problem.

"It calls for study of the problem.

"It calls for public education on the subject of alcoholism.

"It omits all mention of punishment as a means of controlling the problem.

"It recognizes the necessity of diagnosis, the possibility of various forms of treatment and the advisability of probationary rather than institutional treatment whenever possible.

"It offers free service to those requesting it.

"It recognizes that many groups, individuals and official bodies have interests which are affected by the problem of alcoholism and that they have skills which may be required if rehabilitation and eventual prevention are to be realized.

"It has accepted the principle of separate administration.

"It has located responsibility in a new state board and has given to that board sufficient discretion and power."[16]

"The Commission plans to open its first clinic in Hartford and to expand the services of the Yale Plan Clinic by contractual arrangement, just as soon as possible. In addition, it plans to open other clinics in the State within its budget limitations, as fast as arrangements can be made and personnel secured. These facilities will be

[12] Public Welfare Council, State of Connecticut, *The Needs of the Chronically Ill and Aged in Connecticut* (Abstract of Report by the Public Welfare Council to the 1945 General Assembly and to His Excellency, Raymond E. Baldwin, Governor), January 1945, pp. 6–7.

[13] *General Statutes of the State of Connecticut, 1945 Supplement*, Chap. 147, Sec. 611h–615h.

[14] Public Act No. 406, Connecticut General Legislative Assembly, 1945.

[15] From statement provided by the Connecticut Commission on Alcoholism to the New York State Health Preparedness Commission, May 1946.

[16] Selden D. Bacon, "New Legislation for the Control of Alcoholism: The Connecticut Law of 1945," *Symposium on the Problem of Alcoholism in Postwar Planning*, p. 200. (Reprinted from *Quarterly Journal of Studies on Alcohol*, New Haven: September 1945.)

designed to provide professional services for alcoholism on an out-patient basis. The professional personnel of such a clinic would consist of a psychiatrist, two psychiatric social case workers, and the consulting services of a psychologist, a general physician and special hospital facilities.

"Plans for the establishment of convalescent units for those patients needing more than ambulatory care for a limited period of time, and a facility for the commitment of alcoholics by courts, are proceeding hand in hand with the plans for the establishment of the clinics.

"The Commission expects to establish close contact with hospitals and with private, municipal and State social agencies, and to develop relationships with these resources, that will be of mutual benefit in caring for the alcoholic and members of his family."[17]

ILLINOIS

Background

Planning for more adequate care for the chronically ill is commanding increasing interest and official support in Illinois. Until recent years some organized voluntary groups were interested in promoting more adequate care for the tuberculous, others were interested in the orthopedically handicapped and still others in promoting State facilities for cancer patients. Paralleling these activities, county officials were becoming concerned about the role of public homes and infirmaries.

With the advent of the Old Age Assistance and Aid to the Blind programs, the able bodied population of the county homes began decreasing, some counties closed their public homes, others rented their facilities to individuals for operation as proprietary nursing homes, and still others were contemplating converting their plants into public nursing homes for the infirm and chronically ill. During 1944 the Illinois Public Aid Commission surveyed the 83 local public homes then in operation. They found 27 probably convertible into nursing homes with minor renovations, 23 possibly convertible with substantial renovations and 30 in too poor condition to justify the large expenditures necessary to insure adaptability. A year later, in March 1945, the number of public homes had decreased to 72 and, with aggregate accommodation for 7,264 persons, only 4,303 inmates were under care, a percentage occupancy of 59.2 per cent.[18] Four-fifths of this population was estimated to be in need of continuous nursing service and medical care.[19]

Legislative Committee to Investigate Chronic Diseases Among Indigents

In 1943 the Sixty-Third General Assembly created the Legislative Committee to Investigate Chronic Diseases Among Indigents. Its findings have been based on authoritative publications, evidence presented at a public hearing, estimates of the magnitude of the problem and the availability of facilities for the care of the chronically ill in the State. The conclusions of this Committee were reported on June 7, 1945, to the Sixty-Fourth General Assembly of Illinois, and are summarized as follows:[20]

1. Chronic disease is not limited to the aged but prevails in all age groups.
2. Today one of every two deaths is due to chronic disease whereas 75 years ago only one of every 15 deaths was due to this cause.
3. The prevention of chronic illness is important in preserving good public health, in conserving economic productivity and averting serious social and economic complications. Public action is, therefore, mandatory to combat its imminent increase and unquestioned ravages.
4. The Committee was originally charged with determining the extent of chronic illness among the indigent, the facilities available for their care and the need for additional facilities and services for this group. However, becoming convinced that sound planning dictated consideration of all the chronically ill, the Committee broadened its investigation to cover *all* the chronically ill, regardless of economic status.
5. ". . . Illinois now has approximately 90,000 persons whom chronic disease has reduced to invalidism. An additional 270,000 persons are so seriously afflicted with chronic disease or permanent impairment of one kind or another that they also may require specialized services and care from time to time."[21]
6. Partial information indicates that facilities for the care of the chronically ill are insufficient in number, are unequally distributed geographically and many are substandard in quality. The Committee, therefore, suggested that further study be initiated to provide additional facilities, with consideration being given to the following:
   (a) "The possibility of setting aside more beds in general hospitals for patients who are chronically ill, or of establishing infirmary facilities in connection with general hospitals.
   (b) "The possibility of converting County Homes which can be so converted into homes for the infirm and chronically ill, with proper regard to construction, sanitation, and general hygiene so as to safeguard the health, safety and comfort of the patients.
   (c) "The possibility of establishing additional tuberculosis sanatoria, with attention to their proper distribution so as to provide ready access to tubercular patients in all parts of the State.
   (d) "The possibility of establishing additional infirmary facilities in private institutions for the aged.
   (e) "The possibility of establishing additional private nursing homes and homes for convalescent

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[17] From statement provided by the Connecticut Commission on Alcoholism to the New York State Health Preparedness Commission, May 1946.

[18] Illinois Public Aid Commission, "Contribution of the Rennick-Laughlin Bills to Improve Care of the Chronically Ill in Illinois," *Public Aid in Illinois* (August 1945), p. 4.

[19] State of Illinois, Committee to Investigate Chronic Diseases Among Indigents, *Interim Report to the Sixty-Fourth General Assembly*, June 7, 1945, p. 9.

[20] *Ibid.*

[21] *Ibid.*, p. 3.

care, under competent management and with proper standards, licensed, and supervised by a state agency or by local governments in conformity with state standards.

(f) "The possibility of establishing additional home nursing and housekeeping services."[22]

7. The growing tendency among the private institutions for the aged to develop facilities for care of the chronically ill may increase as the problem of these patients becomes better known and "as equitable bases of payment for care in such institutions are developed in coordination with payment rates for other types of facilities."
8. Facilities and services for the chronically ill of all economic classes should be promoted and/or established; should be properly coordinated and located; and should include diagnostic and treatment facilities and personnel, hospitals, nursing homes, custodial units and homes for persons requiring neither hospitalization nor nursing care who do not have adequate homes of their own. Institutional care should only be used where medically indicated or as a last resort, preference being given to the care of the patient in his own home.
9. No recommendation on the erection of capital facilities was made because of (a) the wartime lack of materials and manpower and (b) the costliness of construction and (c) the possibility that a policy of institutionalization for the chronically ill might be detrimental to the morale and rehabilitative potentialities of such patients.
10. The State of Illinois should enact legislation establishing a proper body to continue the study of needs of the chronically ill and make recommendations for the solution of this problem.

Action Taken Recently the State of Illinois has taken steps to alleviate the pressing problem of chronic illness.

Change of Function of Public Homes. A series of four bills, known as the Rennick-Laughlin bills, were introduced and passed by the State Legislature (1945) and enacted into law. They recognized the advisability of removing the pauper stigma from public homes; deleted all references to "poor houses"; established the county homes as medical facilities to care for infirm and chronically ill persons, whether destitute or able to pay for maintenance;[23] permitted public homes meeting the requirements of the Illinois Public Aid Commission to admit appropriate Old Age Assistance and Aid to the Blind recipients without the client losing his categorical relief status;[24] and permitted counties not having their own eligible plants to send appropriate cases for care to neighboring counties having acceptable facilities.[25]

Subsequently, the Illinois Public Aid Commission formulated and published minimum standards which the converted facilities, formerly known as "county homes," must meet if their Old Age Assistance and Aid to the Blind recipients are not to lose their categorical relief status. The standards cover fire and safety hazards, medical and nursing care, physical arrangements, financial practices and procedural arrangements between local and State officials.[26]

By April 1946 eight former county "poor houses," having a combined capacity of 445, had been converted into modern institutions for the care of the chronically ill in accordance with the provisions of the Rennick-Laughlin bills; and approximately 35 others were in the process. These conversions are well described in both words and photographs in a recent issue of "Public Aid in Illinois."[27]

Concurrent with the physical transformation of the county homes, the Illinois Public Aid Commission is endeavoring to raise the quality of medical care and treatment provided; and is considering means of conducting research in the medical problems of the aged in cooperation with qualified research organizations. Among other aspects, such study would include inquiry into the mental manifestations of those aged not sufficiently ill to be committed to mental hospitals. In addition to applying the findings to the patients of the county homes, the Commission is hopeful that they might also be made available for the benefit of those chronically ill and aged not being cared for in institutions.[28]

Licensure of Nursing Homes. In the fall of 1944 the Illinois Public Aid Commission made available Old Age Assistance and Aid to the Blind grants in excess of $40 monthly for nursing home care. This action encouraged the use of nursing homes by local assistance officials and stimulated counties with suitable public homes to consider converting their plants into facilities to care for the infirm and chronically ill. And in January 1945 the Commission assumed responsibility for the payment for all medical needs (up to $75 per month) and hospital needs of Old Age Pension and Blind Assistance recipients.

The 1945 Session of the Legislature passed, and the Governor signed, a law making licensure of proprietary and voluntary nursing homes by the State Depart-

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[22] *Ibid.*, p. 19.

[23] *Laws of the State of Illinois, Sixty-Fourth General Assembly, 1945*, "County Homes" (Senate Bill No. 212, approved June 13, 1945), pp. 1136–1138: "County Homes Established" (Senate Bill No. 213, approved June 6, 1945) pp. 1138–1140.

[24] *Ibid.*, "Old Age Pension—Inmates of Homes" (Senate Bill No. 210, approved June 6, 1945), pp. 407–409; "Blind Assistance—Inmates of Homes or Institutions" (Senate Bill No. 435, approved July 24, 1945), pp. 400–401.

[25] Raymond M. Hilliard, "The Development of County Homes for Care of the Chronically Ill," *Public Welfare* III (December, 1945).

[26] Illinois Public Aid Commission, "Rules and Regulations in Regard to Standards for Safeguarding Health, Safety and Comfort of Inmates of County Homes for the Destitute, Infirm and Chronically Ill, and to Compliance Therewith," *Public Aid in Illinois*, November 1945, p. 10.

[27] Norman T. Paulson, "Eight Illinois County Homes for the Chronically Ill Demonstrate Constructive Local Action Possible Under New Legislation," *Public Aid in Illinois*, April 1946, pp. 1–5.

[28] Illinois Public Aid Commission, *Opportunities for Medical Research Presented by Illinois County Homes for the Chronically Ill*, Feb. 21, 1946. Also, *Minutes of Joint Meeting of Commission and Representatives of Specified Medical Organizations*, Feb. 21, 1946.

ment of Health mandatory.[29] Within ten days the Department had mailed copies of the act and application forms for licensure to the nursing homes in the State and by late fall of the same year had formulated regulations and initiated inspections as required by the legislation.[30]

In this connection it should be noted that at the same Legislative Session two bills (House Bill No. 103 and Senate Bill No. 373) were introduced but not passed. Either would have authorized the State Department of Health to license and regulate a wider coverage of public, voluntary and private institutions caring for ill persons, i.e., hospitals, lying-in homes, rest homes, nursing homes, sanatoria and boarding homes.

Payment for Care of Old Age Pension and Blind Assistance Recipients in Private Non-Profit Institutions (such as homes for the aged). Such payments in Illinois have been on a "deficit financing" basis, i.e., the differential between per capita cost of care and per capita general income of the respective institutions. This practice has been administratively cumbersome, has discouraged the admission of public assistance recipients and has deterred the extension of facilities of the homes for the care of the chronically ill. And yet such institutions, along with the "county homes" and nursing homes, are the only appropriate ones available for chronically ill patients requiring care outside their own homes, but not hospitalization.[31]

The Illinois Public Aid Commission is, therefore, considering revising its policy of payment so that rates might be negotiated with each home at an amount not exceeding the per capita cost of care, exclusive of capital expenditures.[32]

State Tuberculosis Sanatoria. Illinois, unlike practically all other states, neither operated State tuberculosis hospitals nor granted state aid for care of the tuberculous in local sanatoria. This practice is now obviated, for the Legislature (1945) appropriated $3,850,000 for the construction of five State operated tuberculosis sanatoria. The plans for these facilities are being developed by the Illinois Postwar Planning Commission.[33]

Extension of Services to Physically Handicapped Children. Services and facilities for the care of handicapped children have been extended and are being administered by the State Department of Public Welfare. In addition to other benefits, the Hospital School for Severely Handicapped Children has been established in a Chicago building formerly occupied by a general hospital. It will provide nursing and medical care services. Although intake is now confined to children of kindergarten age through the eighth grade, care may later be extended to patients up to age 21, as provided by law. Children admitted must be educable and must fulfill specified diagnostic criteria. The supervision of the educational program is the responsibility of the Superintendent of Public Instruction. An appropriation of $420,000 was made for the program.[34]

Planning for the Future. Three recent significant developments promise rather immediate and comprehensive medical care planning in the State. (1) The State Department of Health, assisted by an Advisory Council appointed by the Governor, has almost completed a state-wide survey of health and medical care capital facilities. (The findings to date indicate that approximately 15 per cent of the beds in the general hospitals of Illinois are occupied by chronically ill patients.) (2) The Legislative Commission to Investigate Hospitalization and Medical Care has been appointed to study the hospital and medical care needs of the citizens and to report thereon to the 1947 Legislature.[35] (3) The Committee to Investigate Chronic Diseases Among Indigents has been succeeded by the Commission on Care of Chronically Ill Persons.[36]

The latter consists of representatives of the State House and Senate, the Director of the Department of Public Welfare, the Director of the Department of Public Health and the Public Aid Director of the Illinois Public Aid Commission. Unlike its predecessor, this new Commission is charged with considering the adequacy and need of offical and private facilities and services for *all* chronically ill persons and the feasibility and means of providing state assistance for this purpose. It is to report to the 1947 Legislature. An appropriation of $20,000 was made for the operation of the Commission.

Proposed Legislation Not Enacted Into Law The 1945 Legislature also considered, but did not enact into law, a bill to establish the Illinois State Cancer Hospital under administration of the State Department of Public Welfare. This legislation included an appropriation of $1,500,000 to cover construction, operation, maintenance and equipment.[37]

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[29] *Laws of the State of Illinois, Sixty-Fourth General Assembly,* 1945, "Nursing Homes—License" (House Bill No. 252, approved July 17, 1945), pp. 1159–1162. New York State Health Preparedness Commission, "Licensure of Nursing Homes in Other States," mimeographed May, 1946. (Reprinted infra, pages 94 and 95.)

[30] Roland R. Cross, M. D., "State Department of Public Health Assumes Responsibility for Licensing Nursing Homes," *Public Aid in Illinois,* November 1945, p. 3.

[31] Illinois Public Aid Commission, *Recapitulation of Issues Involved in Determination of Commission Policy for Payments for Care of the Aged and the Blind in Non-Profit Private Institutions,* Sept. 28, 1945.

[32] Illinois Public Aid Commission, *Private Institution Policy,* Feb. 1, 1946.

[33] *Laws of the State of Illinois, Sixty-Fourth General Assembly, 1945,* "Public Works" (Senate Bill No. 417, approved July 17, 1945), pp. 248–263.

[34] *Ibid.,* "Physically Handicapped Children" (House Bill No. 412, approved June 29, 1945), pp. 418–419.

[35] *Ibid.,* "Commission to Investigate Hospitalization and Medical Care" (Senate Bill No. 336, approved July 18, 1945), pp. 100–101.

[36] *Ibid.,* "Commission on Care of Chronically Ill Persons" (Senate Bill No. 436, approved July 18, 1945), pp. 97–98.

[37] Sixty-Fourth General Assembly, State of Illinois (1945), *Senate Bill No.* 191.

Control of Alcoholism The Committee on the Problem of Alcoholism, organized in 1944 by the Illinois State Department of Public Welfare, has been instrumental in promoting a treatment program for inebriates. It is being carried on in wings of the diagnostic units in two of the state mental hospitals, Chicago State Hospital and Manteno State Hospital. Staff psychiatrists have a limited and selected group of patients under care, are using intensive psychotherapy techniques and are working in conjunction with Alcoholics Anonymous. No extensive building program for capital facilities for these patients is contemplated, pending evaluation of the results of the present method of treatment.

INDIANA[38]

The State of Indiana is reputedly the first to have officially incorporated into its public health program a service for the prevention, treatment and amelioration of the diseases and disabilities of the aged.

Unlike the studies and reports made in some states to determine the extent, problems and needs of the chronically ill as a basis for planning for such patients, the impetus for establishing this service in Indiana did not stem from any study or survey, but from its public health and medical leaders. They called attention to the increasing proportion of the population over 45 years of age, the fact that 350,000 citizens of the State are 60 years of age or older, and the possibility of extending the productive years of the aged to lessen the ravages of senility.

Legislative Action As a result, the 1945 State Legislature added a section to the general health law of the State which provided that "the State Board of Health shall provide facilities and personnel for research investigation and dissemination of knowledge to the public concerning the health of persons of middle and advanced age and diseases common thereto. . . . The State Board of Health is hereby vested with discretion in providing the means and methods for such research, investigation and dissemination of knowledge and may make, adopt and promulgate rules and regulations for the purpose of establishing proper facilities and personnel and to carry on the work described in this section."[39]

Purpose Subsequently the Division of Adult Hygiene and Geriatrics was established within the State Board of Health with the following principles and objectives:

1. To study the factors of life that are related to senescence and senility as these are influenced by age, environment, heredity, and the diseases and disabilities associated with advancing years.
2. To be interested in and plan for the health and well-being of that part of our population whose advancing years and life experience entitle them to the best protection that medical knowledge and care can provide.
3. To help the public to know that senescence is normal; that senility is no more a necessary part of age than is rickets of childhood; and that through better understanding much of the premature deterioration of age can be prevented.
4. To have the public informed on all helpful, preventive knowledge concerning diseases and disabilities of advancing age; and to encourage the medical profession, through teaching and practice, to become more interested in the problems of age, particularly in the anticipation of preventable diseases of age and advancing years.
5. To cooperate with and assist, as far as possible, both the public and medical profession as well as public officials and others in a full appreciation of the economic, social and cultural value and usefulness of men and women who by reason of age and experience constitute a most important group of our population.
6. To be interested in all laws, rules and regulations, legislative, industrial, social and others, which may affect the well-being and usefulness of old age, and to seek the improvement of such laws, rules, regulations and requirements as may affect old age adversely.

Doctor William F. King, Director of the Division, in a letter to the New York State Health Preparedness Commission on February 25, 1946, stated that: "A program of this kind necessarily includes many facts and factors aside from diseases and disabilities of aging people. It includes the preparation of physicians for their essential part in such a program through geriatric teaching in medical schools. It includes the intelligent cooperation of industry in order that men and women who are capable and who can work may not arbitrarily be retired from active work because of having attained a certain number of birthdays. It includes problems of adult education and adult adjustment in order that capable aging persons may still have an opportunity to continue to be productive and self-supporting. It includes practically every phase of preventive medicine and public health administration because the health and physical and mental well-being of aging people must be the result of all that has gone before in the way of health work, social work, education, medical care, and practically every other influence and factor that enters into life."

The Program In formulating its program, Indiana has (1) initiated some first steps and (2) has considered others as possible future projects.

The Division is currently preparing informational pamphlets for distribution to the general public and professional persons, is encouraging physicians to become interested in geriatrics and is urging adults to avail themselves of periodic physical examinations and health consultations as preventive measures. In addition, a survey of industries is being conducted to ascertain their practices governing retirement and maximum employment ages.

[38] This presentation is based on correspondence with the Indiana State Board of Health and *American Journal of Public Health*, American Public Health Association, Vol. 36, No. 2 (Feb. 1946), pp. 202–203.

[39] *Acts of the Indiana Legislature*, Chap. 352, Sec. 6a, approved March 10, 1945.

Contemplated projects for future development include the promotion of geriatric teaching; the enlistment of industrial cooperation in not arbitrarily retiring employees solely because of chronological age; adult education and adjustment to maintain the productivity and mental alertness of the aged; and possibly surveys of nursing homes, homes for the aged and hospital and clinic facilities, especially as related to the medical problems of the aged. In addition, the Division is preparing to cooperate with the State Medical Society and the State Cancer Society in a state-wide program of cancer control to be based on the best experience of other states in carrying out an effective Cancer Control Program. This program is now being set up and will be extended as rapidly as facilities can be created for carrying out the program successfully.

Conclusion Indiana, in creating its Division of Adult Hygiene and Geriatrics, has thus established a *continuing* agency specifically concerned with the problems of senility. It intends not only to coordinate, promote, interpret and ascertain facts on senility and ultimately plan for the proper care of the chronically ill, but it is also concerned with the prevention and amelioration of the medical, mental and social ravages and with fostering the continued productiveness of the aged.

MARYLAND

Background Planning for the chronically ill in Maryland has stemmed from from an appreciation of the type of care required but not given to inmates of public homes, a realization that this population is but a small segment of all the chronically ill and the recognition of chronic illness as a major medical problem.

Like most states, Maryland historically used the county almshouse, or workhouse, as a facility where indigent inmates might earn their "keep" by producing goods for sale. These institutions, beginning in 1768 and usually including farm operations, experienced successive decreases in their populations as land was opened in the West, the mentally ill were transferred to the newly established public mental hospitals and laws were passed prohibiting children being placed in the almshouses. Although the "almshouse" was legally changed to "county home" at the beginning of the century, there was little corresponding change in the character of the institution itself. However, in the last two decades there has been a recognition of the need for more conscious planning and improved care for the inmates of public homes, as evidenced by official State authorization of studies of the situation completed in 1931, 1933 and 1938. All pointed to great inadequacies in the physical equipment but no ameliorative action was taken.

Report on Almshouses, 1940 In 1939 the State Senate requested the Legislative Council of Maryland to survey and report the current condition of the almshouses. This study was made for the Council by the State Department of Public Welfare in cooperation with the almshouse physicians, local health officers, State Fire Marshal, State Commissioner of Mental Hygiene and county welfare boards.[40]

In December 1939, 15 of the 23 counties in the State, Baltimore City excluded,[41] still had county homes. They were caring for 556 inmates, of which three-fifths were 65 years old and over, and more than two-thirds were men. The majority were bedridden. Most of the rest were physically and mentally handicapped, requiring expert nursing and medical care. An analysis of the physical and mental characteristics of 510 of these inmates indicated the following:

TYPE PLACEMENT NEEDED	Number	Per Cent
Total	510	100.0
Homes of relatives or boarding homes	96	18.8
Mental hospitals	95	18.6
Other institutional care for physical or mental reasons	319	62.6

The group needing "other institutional care," half of whom were bedridden, were chronically ill individuals, crippled, deformed, rheumatic, arthritic, paralyzed, deaf, blind, suffering from heart involvements, cancer and similar illnesses.

Despite general impressions, the county homes in Maryland were not a "dying institution." Their populations were not decreasing, but had remained relatively stationary in the 10 years preceding the study. In fact, half the inmates under care in December 1939 had been admitted in the immediately previous triennium.

Since inmates could be transferred to the homes of relatives and boarding homes under existing public assistance programs, and the mentally ill requiring hospitalization were the responsibility of the State Board of Mental Hygiene, the study concluded that the immediate need was for the establishment of institutions to care for the residual group, the chronically ill. It recommended the establishment of chronic hospitals with a homelike atmosphere to be located near approved general hospitals and simultaneously urged careful consideration of two points: (a) The probability that the number of chronically ill in the public home population represented only a part of a much larger problem of chronic illness. (b) The possibility

[40] Maryland Legislative Council, Research Division, *Report on Almshouses in Maryland*, April 1940.

[41] Baltimore City is not in a county.

of converting some of the public homes (total assessed value $800,000) so that they might provide a different type of care.

The Almshouse Commission, 1940 The Almshouse Commission, appointed by the Governor to consider this survey of almshouses and make recommendations thereon, submitted its report in November 1940.[42] The Commission reviewed the studies of the county homes made in 1931, 1933, 1938 and 1940 and also a study of the need for increased hospital facilities for the chronically ill in Baltimore City.[43] It considered the methods by which other states and cities had alleviated or planned to solve the problem of adequately caring for the chronically ill; and it subscribed to the premise that action should be taken to ameliorate the *total* problem of chronic illness in the State, of which the public home population was only a part.

The recommendations of this Commission are summarized as follows:

1. *Construction.* Two chronic hospitals, with aggregate capacities of 1,710 beds and located near approved general hospitals, should be built to serve the county populations. Each institution should consist of a hospital and an infirmary section, meet modern standards for such facilities and be planned to allow for future capital expansion. In addition, the existing chronic hospital unit of the Baltimore City Hospitals should be expanded.
2. *Admission Policy.* The hospitals should admit patients who are in need of long-term nursing, medical or infirmary care who cannot be otherwise cared for and who cannot pay for such care elsewhere. No patients should be admitted who have tuberculosis in a transmissible form, mental disease requiring care in a mental hospital or orthopedic disease admissible to the special orthopedic hospitals, or who are under 16 years of age.

   In connection with the latter prohibition, the Commission recognized the inadequacy of facilities for the care of chronically ill children, and urged that consideration be given to the possibility of adding wings to the proposed hospitals for child patients in the future.
3. *Financing.* The State should assume the cost of the capital construction, repair and upkeep of the chronic hospitals and aid with the expansion of the corresponding Baltimore City facility. The respective counties should pay $.75 per day for each of their residents under care in the hospitals, regardless of whether care was being provided in the hospital or infirmary section of the institution, or temporarily in a general hospital. The State should pay the difference between the $.75 per diem and the actual cost per day.
4. *Administration.* Each of the chronic hospitals should have a Board of Visitors, representative of the counties served by the institution, which would be responsible for making suggestions for the proper operation of the facility. It was recommended that the two hospitals intended to serve the counties be administered by the State Department of Public Welfare, assisted by a technical medical advisory committee.

Action Taken A bill was introduced into the 1941 Session of the Legislature which, in addition to implementing the foregoing recommendations of the Almshouse Commission, simultaneously abolished the county homes, or almshouses. This legislation failed to pass.

A bill deleting reference to the abolition of county homes was passed by the Legislature and approved in 1943, and amended in 1945.[44] In most respects this law incorporated the recommendations of the Almshouse Commission. It provided for the construction of three instead of two chronic hospitals at State expense, each with hospital and infirmary sections, and specifically stated that the architectural plans should allow for future expansion. In addition to the admission policies suggested by the Commission, the law required that admission be based on the statement of a physician following an examination, that "no patient shall be admitted who is able to pay the cost of proper hospital care elsewhere." Unlike the recommendations of the Almshouse Commission, the law placed administrative responsibility for the hospitals with the State Board of Health and made no provision for a technical medical advisory committee, but provided that financial eligibility be determined by local welfare officials.

Although this legislation made no provision for the expansion of the Baltimore City facilities for the care of the chronically ill, this might not necessarily preclude the State from making financial aid available for this purpose in future appropriation legislation.

Since the passage of this legislation, one county has abandoned its almshouse, the Legislature has appropriated $2,500,000 for construction of the three hospitals to be located in the counties, and the sites for these institutions have been selected. Current limitations on manpower and materials have temporarily deferred construction and, although bids have been opened for one of the hospitals, they have been rejected because of the increase of actual cost beyond estimated cost.

MASSACHUSETTS

Care, of the Chronically Ill Massachusetts has been gradually and steadily providing more adequate treatment and diagnostic facilities for the care of the chronically ill. Since it has tended to concentrate on specific disease entities successively rather than on a comprehensive, all inclusive plan, its approach is probably better described as a general policy than as a formal plan or blueprint. On February 1, 1946, Doctor Vlado A. Getting, Commissioner of the Massachusetts Department of Public Health, wrote as follows to the New York State Health Preparedness Commission describing the plan of his State for the care of the chronically ill:

> "The provisions for the care of individuals suffering from chronic disease are in a formative state at the present time.

[42] Almshouse Commission of the State of Maryland, *Report of the Almshouse Commission*, November 22, 1940.

[43] Baltimore Council of Social Agencies, *Chronic Hospital Care*, November 1940.

[44] *Annotated Code of Maryland* (1943 Supplement), Art. 43, Sec. 526–530.

The Massachusetts survey, reported in 1933, showed that one person in eight in the state was afflicted with some form of chronic disease. The population of Massachusetts is growing older, and since chronic disease increases with age, more rather than less chronic disease is to be expected.

"The General Court (state legislature) has already sanctioned the Department's participation in chronic disease by its authorization of the cancer program, and by its annual appropriation of funds for the maintenance of 20 beds at the Massachusetts General Hospital for the study and treatment of cases of arthritis.

"At the last session of the General Court an appropriation of $200,000 was authorized to formulate plans for a new chronic disease hospital of 800 beds. The administration of the Hospital will be under the Division of Tuberculosis. Other activities for the control of chronic disease will be under the supervision of a Division of Cancer and Other Chronic Diseases.

"There should be three parts to the program:—education, research and clinic. The Department has authority for the first two at the present time, but additional legislation is needed for clinics. They are necessary inasmuch as the volume of chronic disease cases needing service greatly surpasses the number of contemplated beds and since the patient's stay in the hospital will be limited.

"Patients discharged will be referred to the clinics working with their physician, if they have one, for the supervision of the treatment outlined in the hospital.

"It is planned to establish 18 clinics in various centers throughout the state. Clinics on each disease will be held once or twice a month. They will probably be located in the local hospital. The actual method of reimbursing these institutions has not yet been worked out. The clinics will be headed by a consultant conversant with the disease under consideration, aided by other physicians from the locality in which the clinic is situated. The remaining personnel of the clinics has not been determined, but it will undoubtedly consist of at least one record clerk to keep accurate records on forms furnished by the Department and a social worker. I have also appointed an Advisory Committee of 11 composed of representative physicians to formulate a plan for clinics which the Department can adopt.

"Construction of the chronic disease hospital has not yet begun, and it probably will be some time before the clinics are in operation and the entire program is underway."

Control of Alcoholism

The Special Commission to Investigate the Problem of Drunkenness in Massachusetts was created by the 1943 General Court (state legislature)[45] and reported to that body March 7, 1945.[46]

The Commission, in general, considered the medical, social and penal implications of alcoholism, securing much of its information from public hearings, testimony of experts, publications and factual data. Its report stresses the need for education on the use of alcohol, cites the apparent failure of correctional penology and comments upon the proportion of mental disease due to inebriety. The major recommendations made by the Commission are as follows:

1. Strengthen the teaching of public health education in the public schools, including instruction relative to alcoholic overindulgence.
2. Label alcoholic beverages to include information on their proper use and possible effects if used excessively.
3. Allow only one release from custody, without arraignment, to persons arrested for drunkenness in any one year. (Four now permitted.)
4. Forbid "nol prossing" of drunkenness cases without concurrence of a justice of a Superior Court.
5. Use existing statutory and administrative machinery more effectively to improve the socio-penological aspects of the handling of drunkards.
6. Establish a hospital for early and moderate alcoholics, possibly under the jurisdiction of the State Department of Mental Hygiene.
7. Create a personal use license for users of intoxicating beverages, the income therefrom to be designated for care, study and research relative to alcoholism.
8. Establish a commission for the continuous study and investigation of alcoholism.

In addition to considering legislation relating to the manufacture and transportation of intoxicating beverages and the handling of cases of drunkenness by the courts, the 1946 General Court has pending before it a bill providing for the establishment of a hospital for the treatment and study of alcoholism.[47]

NEW JERSEY[48]

Although New Jersey has not formulated a comprehensive plan for the care of the chronically ill, the State Department of Institutions and Agencies, established in 1918, has been the spearhead in calling attention to this medical-social problem; in creating a public consciousness of the needs of the patients; and in providing leadership and assistance in developing facilities. The Department, motivated by a desire to provide adequate medical and social services for the recipients of public assistance handicapped by long-term illnesses, has been aware of the ever increasing incidence of chronic disease in the total population and the imperative need for improved services for all the chronically ill, regardless of economic status.

The State has three milestones in improving the care of the indigent chronically ill: the permissive act of the 1924 State Legislature allowing counties to establish welfare houses; the Nursing Home Act of 1927 providing for the licensure of non-public nursing homes; and the Joint Resolution of the 1931 Legislature calling for a survey of the chronically ill.

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[45] Commonwealth of Massachusetts, *Resolves of 1943*, Chap. 62.

[46] Commonwealth of Massachusetts, *Report of the Special Commission to Investigate the Problem of Drunkenness in Massachusetts* (Boston, 1945).

[47] General Court of the Commonwealth of Massachusetts, *Senate Bill No.* 386, 1946.

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E. C. Potter and others, "How Can a Program for Care of the Chronically Ill Be Integrated?" *Public Welfare*, I (November 1943), pp. 326–332, (December 1943), pp. 364–370.

State of New Jersey Department of Institutions and Agencies, *Report on Chronic Disease in New Jersey* (Trenton: May 1932).

Nursing Home Licensure

The licensing of nursing homes by the Department of Institutions and Agencies began in 1927 after a growth of nursing homes was noted and control of their standards was considered to be in the public interest.[49] The details of this licensing are described elsewhere in the present report.[50]

New Jersey does not merely inspect and license nursing homes on a routine basis. It maintains a continuing contact with the proprietors who are encouraged to request advice and consult the inspectors on their nursing home problems. Thus the Department carries on a continuous educational process, teaching the proprietors how best to operate efficient, safe homes and provide adequate professional nursing and medical services for the patients. As a result, the homes tend to improve and acquire stability rather than merely meet official requirements; and the Department becomes conversant with the nursing home problems at first hand and can, therefore, be flexible and realistic.

By action of the 1942–1943 State Legislature the ceilings were removed from Old Age Assistance grants in New Jersey. Subsequently, the Department of Institutions and Agencies raised the maximum nursing home fees reimbursable for Old Age cases to $80 per month, the local government paying 25 per cent of the cost and the State 75 per cent of the amount above the Federal "normal" grant.[51] Liberalizing the reimbursement formula has encouraged the nursing homes to accept aged indigent persons and has stimulated local welfare departments to place their aged patients in homes best suited to their medical and nursing needs.

Welfare Houses

From colonial times the counties of New Jersey, like those of other eastern states, have maintained "poor farms" or almshouses to provide shelter and board for the indigent. In more recent years, they often have served as the depositories for the indigent chronically ill requiring nursing or custodial care rather than hospitalization, despite the fact that the institutions did not provide proper medical and nursing services.

Under the permissive legislation of 1924, several of the counties established welfare houses, institutions for the indigent ill (exclusive of tuberculous and mental cases) requiring long-term medical and nursing care but not service in a general hospital. In its official supervisory capacity, the Department of Institutions and Agencies has participated in the planning and in establishing standards of operation of these facilities. Each welfare house is under the jurisdiction of its county welfare board and financed entirely by local funds; has an infirmary or hospital unit for the bedridden and a custodial unit for ambulant patients; has competent, qualified medical, nursing, food service and maintenance personnel; has installed equipment for proper treatment and physiotherapy; and has recognized the human side of care by providing such items as recreation facilities, commissaries, double rooms for couples and church services as integral parts of its program.

As noted above, the State does not now provide reimbursement for the care of patients in welfare houses. However, a bill is being considered by the 1946 State Legislature which would make State funds available for the care of the chronically ill.

Since a single local agency, the county welfare board, operates the welfare house, administers Old Age Assistance and places recipients in nursing and boarding homes, it is possible for this agency to select the place of care of an aged, chronically ill recipient on the basis of his medical and nursing needs. He may remain at home and be cared for by relatives and a visiting nurse; he may be placed in a boarding home and receive periodic care from a visiting nurse; he may be placed in a licensed nursing home; or he may be admitted to the welfare house.

Survey of Chronic Illness

Although the previously described developments are isolated rather than parts of a comprehensive plan, New Jersey did officially recognize chronic illness as a problem in 1931. In that year the Legislature passed a resolution directing the Department of Institutions and Agencies to collect facts relating to "men and women of rational mind who have incurable ailments, diseases and disablements."[52] The Department subsequently made a survey to determine the number of chronically ill in the State, the adequacy of existing facilities for their care and made suggestions as to means of insuring more adequate care to these individuals. The findings were reported in May 1932.[53]

On the basis of a census taken in five counties of the chronically ill under care of social welfare and health agencies, the survey estimated that there were 20,000 chronically ill persons in the State, of whom 6,000 to 7,500 were known to social welfare and health agencies. The analysis of the cases included in the census revealed the following: (1) Two-thirds of the chronically ill were known to agencies providing institutional care and one-third to other agencies. (2) One-fifth of the cases were under 40 years of age, with this younger age group having a greater proportion of partially incapacitated individuals than did the older age group. (3) More than half the cases had been known to some agency for more than a year. (4) The most frequent diagnoses were those of

[49] *Revised Statutes of the State of New Jersey, 1937*, Title 30, Chap. II.

[50] New York State Health Preparedness Commission, Licensure of Nursing Homes in Other States, mimeographed May, 1946. (Reprinted infra, pages 87 to 103.)

[51] Grants up to $40 per month are financed 25% by local, 25% by state and 50% by federal funds. The portion of a grant above $40 per month is financed 25% by local and 75% by state funds.

[52] *Public Laws of the State of New Jersey*, 1931, Joint Resolution, No. 3 (Approved March 30, 1931).

[53] State of New Jersey Department of Institutions and Agencies, *Report on Chronic Disease in New Jersey* (Trenton: May 1932).

diseases of the heart, arthritis and rheumatism, cerebral hemorrhage and shock, cancer and other malignant tumors, paralysis other than cerebral hemorrhage. (5) Only 46.8 per cent of the cases studied were receiving the type of care which they needed, the greatest single inadequacy being the lack of nursing care in institutions.

The survey also noted that in 1930 54.2 per cent of all deaths in the State and 75 per cent of all deaths among persons 60 years old and over were due to chronic diseases. In the older group the most frequent causes of death were organic diseases of the heart, cancer and other tumors, acute nephritis, cerebral hemorrhage and softening of the brain.

Since only a few institutions regarded the care of the chronically ill as their primary purpose, it was suggested that existing facilities be expanded and others adapted to the needs of the chronic patient, as follows:

1. The public welfare houses and almshouses should be equipped and staffed to provide adequate medical and nursing service for the indigent, aged inmates.
2. Hospitals for the chronically ill should be established to provide both the general hospital and nursing home types of services.
3. Visiting nurse service at public expense should be provided for the chronically ill cared for in their own homes.
4. The establishment of additional nursing homes, under State licensure, should be encouraged to care for those patients who, although not requiring hospitalization, cannot be properly cared for in their own homes.
5. Homes for the aged should broaden their admission policies, admit the chronically ill and provide service by qualified nurses.
6. General hospitals should establish wards for the chronically ill, expand their clinic services for use by the ambulant chronically ill being cared for in their own homes, and affiliate themselves with nursing homes which would receive patients following hospital discharge.

In addition to the above findings relative to the chronically ill generally, the survey called attention to the increasing prevalence of cancer, the inadequacy of facilities for the care of these patients, the methods by which this situation might be alleviated and urged the establishment of cancer services and clinics in general hospitals.

Current Interest As previously noted, no official action has been taken on the above report submitted pursuant to Joint Resolution No. 3 of the 1931 Legislature. However, in the latter part of 1945 the need for concerted action and comprehensive official planning was again stressed when the New Jersey Welfare Council passed a resolution, addressed to the Governor, urging that a commission be established to ascertain and develop an inclusive program to meet the needs of the chronically ill in the State.

Control of Alcoholism The New Jersey Commission for the Rehabilitation of Alcoholics and the Promotion of Temperance, created by the 1945 State Legislature and having an initial annual appropriation of $25,000, is responsible for preparing and administering a program for the care, treatment and rehabilitation of alcoholics and for promoting an education program relative to the use of alcohol.[54]

The Commission, wishing to formulate its program on the basis of facts, requested the Department of Sociology of Rutgers University to assemble data on the problem of alcoholism. Recognizing that this complex problem has medical, economic, sociologic, moral and legal aspects, the Department decided to begin its research with a consideration of the medical aspects. This has resulted in a report based on personal interviews with a representative sample of physicians in New Jersey who were consulted relative to the number of alcoholic patients under their care, the relationship of alcoholism to other physical and mental disorders, the methods of treating alcoholics and their suggestions for handling the problem in the State.[55] The summary and recommendations drawn from the interviews were published in the report as follows:

> "This survey demonstrates, in striking contrast to prior speculations on the subject, that many doctors are handling alcoholic patients, that they are articulate about and interested in the problem, that they subscribe to the proposition that the chronic alcoholic is a sick man in need of medical attention, that they feel keenly the unusual problems and burdens placed upon them by patients of this type, that they are groping for help and guidance in dealing with alcoholics, and that they would welcome a sound and constructive program of action.
>
> "The main findings of the survey may be summarized as follows:
>
> 1. "A surprisingly large number of chronic alcoholics (an estimated 29,000) are currently receiving medical attention in the state. And perhaps even more surprising is the finding that 65% of the doctors report having seen chronic cases during the past year. By and large, medical opinion views the chronic alcoholic as a sick man and insists quite specifically that the profession has a control role to play in the problem.
> 2. "Sedation and vitamin therapy are the most frequently used methods of treatment. Although widely accepted by authorities as necessary steps in treatment, they do not constitute any long term or basic approach to the problem of rehabilitation. The practicing physician has neither the time nor the facilities for dealing with such patients on a long term basis.
> 3. "The alcoholic patient, moreover, creates many problems for the doctor. He won't follow instructions, he exhibits annoying characteristics, he's a bad

[54] State of New Jersey, *Senate Bill No.* 231, approved April 4, 1945.

[55] Department of Sociology of Rutgers University, *Medical Aspects of Alcoholism in New Jersey*, Feb. 26, 1946.

medical risk, and he drags his family and his community down with him. In the face of these and other problems the doctors are groping for help.

4. "Ideally, doctors are inclined to think that a relatively long period of hospitalization coupled with psychiatric care constitutes the best treatment. They suggest many available facilities, but a quarter of their suggestions are to out-of-state resources. Above all else, they maintain that the facilities should be specialized.
5. "Substantial majorities favor the various proposed programs of action. They see merit in information centers, clinics and special hospitals. Only 8% go on record as opposing all three of those. Or, to put it another way, 92% would favor some kind of constructive program. And the opinion is overwhelming that the program should be one of state responsibility. The public health aspects of the problem of alcoholism are widely recognized.
6. "The doctors strongly favor a public information campaign on the subject of alcoholism. This clearly indicates a belief that the attitudes and thinking of the public in general, as well as of the victims of alcoholism and their relatives, need to be brought in line with current professional thinking on the problem.

"Several considerations directly or implicitly following from the findings of this report point to the setting up of a state supported information or referral center as an appropriate first move in the development of a sustained program for dealing with the problems created by alcoholism.

1. "This particular proposal was strongly supported by the doctors. They see a real need for such an agency, and their current attitudes indicate that they would make use of it.
2. "An information center would be the most immediately feasible of the various possible steps to be taken. While our findings show the doctors giving somewhat stronger approval to the need for special hospitals, such an undertaking would be the most costly and take the most time to execute of any of the possible next steps. An information center could be set up more quickly and at much less cost.
3. "An information or referral center is, in any event, a necessary first step to any more ambitious program. The findings indicate that a sustained program for dealing constructively with the problem requires far more public education on the subject than now prevails, and improved coordination of the work of the several professional and lay groups who at present come in contact with alcoholics. An information center could appropriately pursue both of these necessary lines of activity."[56]

In addition to the activities of the Commission for the Rehabilitation of Alcoholics, it should be noted that, in March 1946, the New Jersey Department of Institutions and Agencies had an official conference with a private philanthropic group relative to the establishment of an institution for the reception of chronic alcoholics, either as voluntary or as admitted patients. As a condition of operation, such an institution would be subject to licensure regulations addressed to private mental sanatoria. (R. S. 30:10).

[56] *Ibid.*, pp. 4–5.

LICENSURE OF NURSING HOMES IN OTHER STATES—SEPTEMBER, 1946*

INTRODUCTION

This summary of licensure of nursing homes in other states is intended to indicate briefly the trends, coverage, licensing agency, general method, requirements and penalties. It is not intended as an evaluation of the effectiveness of licensure as a control, or of the relative merits of one type of licensure over another, or of one method of enforcement as compared with another. Exhaustive, objective studies of the effect of licensure in the respective states, upon which evaluations should be based, are not available.

This analysis is based on Figure 3 summarizing various aspects of licensure in specified states[1] (pages 92 to 103), the content of which has been approved by the respective licensing agencies;[2] and on summary Table 32 (page 91).

In general, the state licensure laws set forth legal requirements and empower a specified state department to administer the law and to formulate and enforce detailed regulations as a condition of operation of the licensed facilities. Two states have not yet evolved regulations—South Dakota, where the enforcement of the law has been postponed pending a referendum in November 1946, and Texas, where application of the law is deferred pending passage of an appropriation by the State Legislature.

TYPES OF LICENSURE

Nursing homes are licensed in at least 20 states in the United States.[3] In some, licensure is comprehensive, applying to institutions of all types caring for ill persons—nursing homes, general hospitals, special hospitals, tuberculosis hospitals, maternity hospitals and contagious disease hospitals. In others it applies only to nursing homes. In this connection it should be noted that some states officially license only homes caring for the aged, including the aged ill and infirm. In Texas and Nebraska licensure applies only to homes caring for the dependent aged. However, in practice, according to the responsible officials of these respective states, this is tantamount to licensing all nursing homes, for the reason that all such homes either care for aged persons or wish to be permitted to do so.

In some states the impetus for licensure stems from the desire to assure the citizens that the quality of medical care provided in institutions admitting ill persons meets prescribed standards, regardless of the specific type of the medical or medically related institutions. In others licensure has emanated from the concern of public and voluntary welfare agencies regarding conditions existing in institutions caring for their aged, sick and infirm clients.

* This material was previously published in mimeographed form by the Commission in September, 1946.

[1] It is possible that Figure 3 includes all states having licensure but complete coverage is not claimed.

[2] Except for Pennsylvania which has indicated neither approval nor disapproval.

[3] California, Colorado, Connecticut, Delaware, Illinois, Indiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New Jersey, North Dakota, Ohio.

TABLE 28. *Type of Facilities Covered by Licensure Laws of Specified States* *

TYPE OF COVERAGE	Number of States	States
Total	20	
Comprehensive	8	Calif., Colo., Conn., Me., Md., Minn., Okla., S.D.
Nursing homes only	2	Ill., N. J.
Nursing homes for the aged	1	Ind.
Nursing homes and proprietary hospitals	1	Pa.
Facilities for care of the aged and infirm	8	
Homes for the aged, infirm, chronically ill and convalescent	4	Del., Mass., Mo., R. I.
Boarding homes for the aged and infirm	2	N. D., Ohio
Boarding homes for the publicly dependent aged	2	Nebr., Texas

* For details, see Table 32, page 91, and Figure 3, pages 92 to 103.

As shown in Table 28, comprehensive licensure laws are applicable in eight states. Colorado and Connecticut have attained inclusiveness by successively licensing the various types of medical institutions while the other six states legislated complete coverage when licensure was initiated. The remaining 12 states specifically license nursing homes or, as previously noted, homes caring for the aged sick, which generally include nursing homes.

EXCLUSIONS FROM LICENSURE

Practically all the states note specific types of facilities excluded from the provisions of the licensure law. The facilities most often specifically excluded are hotels, institutions caring for persons related by blood or marriage to the operator, institutions with negligible capacities (usually those caring for less than two or three patients), facilities which in good faith rely upon prayer or spiritual means for treatment (but these usually must conform to sanitary regulations), facilities under the auspices of Federal, state, county or local governmental units and facilities licensed or otherwise controlled by a department of government other than the licensing agency. In addition, California, Illinois, and Oklahoma specifically exclude institutions providing care of the mentally ill; Indiana and New Jersey exempt facilities under religious, patriotic or charitable auspices; Massachusetts exempts charitable corporations duly incorporated under state law; Rhode Island and Pennsylvania exclude state aided institutions; and Rhode Island exempts institutions established prior to the passage of the licensure legislation.

EFFECTIVE DATES

On the whole, licensure of nursing homes is a recent development. In 12 states it was started between 1942 and 1946 and in two states (South Dakota and Texas) the enacted legislation is not yet effective. Licensure in the remaining six states was established prior to 1931. (See Table 29.)

TABLE 29. *Year of Establishment of Nursing Home Licensure in Specified States* *

YEAR	Number of States	States
Total	20	
1909	1	Colo.
1927	2	Conn., N. J.
1929	2	Mass., R. I.
1931	1	Pa.
1942	3	Minn. Mo., Ohio
1943	1	Ind.
1944	1	Nebr.
1945	3	Del., Ill., Md.
1946	4	Calif., Me., N. D., Okla.
Pending	2	S. D., Texas

* For details, see Table 32, page 91, and Figure 3, pages 92 to 103.

OFFICIAL DEPARTMENTS RESPONSIBLE FOR LICENSURE

Licensure is the responsibility of the respective state departments of health in 12 states. In eight of these licensure is comprehensive; in the remaining four, licensure covers only nursing homes or their equivalents. In New Jersey administration rests with the Department of Institutions and Agencies, which, in some respects, has duties which in other states are usually the responsibility of welfare and health departments. In seven states the state departments of welfare are responsible for licensure and in these coverage is confined to nursing homes or their equivalents, and usually with stress on facilities caring for the aged or the dependent aged. When the responsible department and the type facility to be licensed are correlated, there is evidence that when responsibility is vested in the welfare department it is most often related to the protection of the aged group rather than to the nursing home population as a whole. (See Table 30.)

TABLE 30. *Coverage of Licensure and Administrative Responsibility for Licensure in Specified States* *

TYPE OF COVERAGE	Total	Responsibility for Administration				
		Health Department		Welfare Department		Other
		No. of States	States	No. of States	States	
Total	20	12	.....	7	.....	1
Comprehensive	8	8	Calif., Colo., Conn., Me., Md., Minn., Okla., S. D.	...	.....	....
Nursing homes only	2	1	Ill.	...	.....	1**
Nursing homes for the aged	1	..	.....	1	Ind.	....
Nursing homes and proprietary hospitals	1	.....	.....	1	Pa.	....
Facilities for care of the aged and infirm	8	3	Del., Mo., Tex.	5	Mass., Nebr., N. D., Ohio, R. I.	....

* For details, see Table 32, page 91, and Figure 3, pages 92 to 103.
** New Jersey where licensure is administered by the Department of Institutions and Agencies.

LICENSURE PERIOD AND FEE

In 16 states the period of licensure is one year, either the calendar year or one year from issuance. The fact that the majority of the 20 states proceed on the latter basis lends credence to the belief that this method makes possible a more economical deployment of licensing manpower and a more even administration by eliminating the need for concentrated inspections of facilities as the calendar year ends. Massachusetts and Rhode Island licenses expire two years from issuance, while Delaware licenses are valid for an indefinite period, expiring only when violations occur.

There are no license fees in four states (Delaware, Massachusetts, North Dakota, Rhode Island) all of which confine controls to nursing homes or their equivalents. In Connecticut, which has comprehensive licensure, fees are required only from private mental hospitals. The remaining 15 states require fees of one of four general types: (1) Seven states have annual licensure fees identical for all sizes of facilities, ranging from $1 per annum in Texas and Nebraska to $25 in New Jersey. (2) Colorado has a $1 fee for the original license with no payment for renewals. (3) Illinois requires $25 for the original license and $5 for each renewal. (4) Six states (California, Indiana, Minnesota, Missouri, Oklahoma, South Dakota) have fees scaled according to the size of the facility licensed, ranging from $5 for six beds or less in Indiana to $50 for 100 or more beds in Minnesota. (See Table 31.)

TABLE 31. *Coverage of Licensure and Type of Fee Required in Specified States* *

TYPE OF COVERAGE	Number of States	Type of Fee Required				
		None	For Original License Only	Renewal Less than Original License	Same Annual Fee for All Facilities	Graduated
Total.....	20	5**	1	1	7	6
Comprehensive.....	8	1	1		2	4
Nursing homes only..	2	..	..	1	1	..
Nursing homes for the aged.....	1	..	..	..	..	1
Nursing homes and proprietary hospitals.....	1	..	..	..	1	..
Facilities for care of the aged and infirm.	8	4	..	..	3	1

* For details, see Table 32, page 91, and Figure 3, pages 92 to 103.
** Includes Connecticut which requires fee only from private mental hospitals.

LICENSURE METHOD

The usual licensing procedure is to require the potential licensee to file application prior to establishing the facility, after which an inspection of the premises is made by the administering agency. A license is issued if the facility complies with the official regulations applicable thereto. Subsequently, periodic inspections, either permissive or mandatory, are made to determine whether regulations continue to be fulfilled and, in some states (New Jersey and North Dakota), to provide continuing consultative service to and supervision of the licensed facilities. Some (California, Maryland, Minnesota, New Jersey, Oklahoma) specifically require that plans for new construction or material remodeling be submitted for approval to the licensing agency. In this connection, it should also be noted that the official licensing departments generally have a working relationship with official state and/or local building, zoning, fire and sanitation authorities who inspect facilities relative to those aspects of licensure which are within their particular fields of competency.

In the states having comprehensive licensure of medical and medically related institutions, the procedure is generally the same as that described above. However, as part of their procedure following receipt of the application for a license, each institution is classified as to type and is required to conform to the regulations formulated for the specific classification.

USUAL REQUIREMENTS

As shown in detail in Figure 3, page 92 to 103, the features most frequently covered by the regulations to be met as a condition of operation are those relative

to location (zoning), building construction, fire protection, sanitation, heating, equipment, accommodations, records of patients and reports to the licensing agency. Specifications vary in detail, and undoubtedly in quality of enforcement, among the states.

A majority of the states include in their regulations requirements relative to admissions, many confining themselves to specifying the general types of patients not to be accepted for care. In several states admissions on a life basis are prohibited. Illinois, Maryland, Minnesota, Nebraska, New Jersey and North Dakota require that definitive information be submitted at the time of admission on the physical condition of the applicant and the care required, such data usually consisting of physicians' reports and recommendations, findings of recent physical examinations and detailed statements of diagnoses.

A number of the states, but far from all, require that at least one registered nurse, or a practical nurse as the alternative, be employed by the licensee and some specifically set forth the maximum ratios of patients to any one nurse. Some states (Illinois, Minnesota, Missouri and Oklahoma) require that physicians take considerable responsibility for supervising the medical care provided, while others merely state that a physician shall be on call.

ENFORCEMENT AND PENALTIES

Except for Maryland, whose law is not specific on this point, licenses may be revoked for cause in all the states, subject to appeal. All have penalties for nonconformance to their licensure laws and regulations, and usually regard such violations as misdemeanors. Penalties also are subject to appeal. Most of the states (12) can apply fines, imprisonment, or a combination thereof, while the others have fines only. Illinois, Missouri, Oklahoma and Texas regard each stated period of violation (day, week or month) as a separate offense liable to additional fines. In Maryland there is an initial fine of $100 and, for subsequent violations, fines up to $500. Fines range from small minimum amounts to be specified by the licensing authority to a maximum of $1,000 in Connecticut and Pennsylvania. Imprisonment allowable is from minimum periods to be specified by the licensing authority to a maximum of six months in Connecticut, Indiana and New Jersey, one year in Pennsylvania and two years in Massachusetts.

In connection with penalties it is interesting to note that in Indiana the falsification of any report on a nursing home by official personnel is a felony, subject to a fine up to $5,000 and imprisonment for one to five years.

TABLE 32. *Summary of Specified Details of Licensure of Nursing Homes in Twenty States, May, 1946* *

STATE	Year of Effective Date of Licensure of Nursing Homes	Coverage of Present Licensure System †	State Department Responsible for Licensure	Licensure Period	Fee per Period
California	1946	Comprehensive ‡	Health	Calendar year	Graduated
Colorado	1909	Comprehensive	Health	Year from issuance	$1 for original
Connecticut	1927	Comprehensive	Health	Calendar year	None except for private mental hospitals
Delaware	1945	Homes for the aged, infirm, chronically ill, convalescent	Health	Until violation occurs	None
Illinois	1945	Nursing homes	Health	Year from issuance	$25 first year; $5 per renewal
Indiana	1943	Nursing homes for the aged	Welfare	Year from issuance	Graduated
Maine	1946	Comprehensive	Health	Year from issuance	$15
Maryland	1945	Comprehensive	Health	Year from issuance	$10
Massachusetts	1929	Homes caring for the aged	Welfare	2 yrs. from issuance	None
Minnesota	1942	Comprehensive	Health	One year	Graduated
Missouri	1942	Homes for aged, chronically ill, incurable	Health	Year from issuance	Graduated
Nebraska	1944	Boarding homes for publicly dependent aged, blind §	Welfare	Year from issuance	$1
New Jersey	1927	Nursing homes	Institutions and Agencies	Year from issuance	$25
North Dakota	1946	Boarding homes for aged, infirm	Welfare	Calendar year	None
Ohio	1942	Boarding, rest, convalescent homes for aged, infirm	Welfare	Year from issuance	$5
Oklahoma	1946	Comprehensive	Health	Calendar year	Graduated
Pennsylvania	Approx. 1931	Nursing homes, proprietary hospitals	Welfare	Year from issuance	$15
Rhode Island	1929	Homes for aged, convalescent	Welfare	2 yrs. from issuance	None
South Dakota	Pending referendum	Comprehensive	Health	Year ending June 30	Graduated
Texas	Pending appropriation	Boarding, convalescent homes for publicly dependent aged	Health	Not specified	$1

* For detailed data and documentation see summary, Figure 3, pages 92 to 103.
† For specific types of institutions excluded from licensure see Figure 3, pages 92 to 103. Exclusions frequently are based on auspices or size of facility.
‡ Comprehensive coverage of all types of facilities caring for ill persons.
§ Recipients of Old Age Assistance and Aid to Blind grants.

FIGURE 3, SUMMARY OF LICENSURE OF

STATE	Reference	Regulations Formulated	Coverage of Licensure		State Department Responsible for Inspection, Licensure
			Specifically Included	Specifically Excluded	
California	State of California, Health and Safety Code, Div. 2, Chap. 2, Sec. 1400–1418, approved July 17, 1945. California Dept. of Public Health, Requirements for Nursing, Convalescent or Rest Homes, approved Dec. 15, 1945. California Department of Public Health, Minimum Fire Safety Standards for Hospitals, approved Dec. 15, 1945.	Yes	"Any institution, building or agency which maintains and operates organized facilities for the diagnosis, care and treatment of human illness, including convalescence and including care during and after pregnancy, or which maintains and operates facilities for any such purpose, and to which persons may be admitted for overnight stay or longer." This includes any hospital, sanatorium, rest home, nursing home, maternity home, lying-in asylum, or clinic providing overnight care.	Federal hospitals. Hospitals operated by the State, counties and municipalities of California. Hospitals operated by recognized religious faiths depending on prayer or spiritual means for healing. Mental hospitals. Hotels.	Department of Public Health.
Colorado	Colorado Statutes Annotated, 1935, Chap. 78, Sec. 61, 124, 133–151. Colorado State Board of Health, Hospitals, Maternity and Convalescent Homes Laws and Regulations (revised 1942).	Yes	General, maternity, contagious disease and tuberculosis hospitals, tuberculosis sanatoria, maternity homes, nursing and convalescent homes (including those for the tuberculous), homes for the aged and disabled and any other institutions for the treatment or care of the sick or injured operated by any person, persons, partnerships, associations, companies or corporations, or which are tax supported.	Maternity hospitals or homes caring for three or less cases during a calendar year.	Board of Health.
Connecticut	State of Connecticut, General Statutes (1930 revision), Sec. 1760, 1761, 1765, 1795, 2391, 2633. State of Connecticut, Cumulative Supplement to the General Statutes, Sec. 369d, 370g, 576e, 682c, 1042e. Sanitary Code of the State of Connecticut, Chap. III, Regulations 199, 200, 200-A, 200-B.	Yes	All hospitals, i.e., "institution for the lodging, care and treatment of persons suffering from disease or other abnormal physical conditions."	State hospitals. Hospitals that receive state aid and are approved by the American College of Surgeons. Tuberculosis hospitals visited by the State Tuberculosis Commission.	Department of Health.

NURSING HOMES IN SPECIFIED STATES, 1946

METHOD	Effective Date	Period Covered by License	Fee per Period	License Revoked for Cause	Penalty	Major Requirements for Nursing Homes	Comment
Application filed on form provided, institution classified as to type, investigation made, license granted if facility complies with regulations for particular classifications. Subsequent investigations made periodically. *Note #1:* Institution classification: 1. Large general hospitals. 2. Small general hospitals and clinics. 3. Maternity institutions. (a) Maternity hospitals or maternity sections of general hospitals. (b) Maternity homes. 4. Tuberculosis institutions. (a) Tuberculosis hospitals and sanatoria. (b) Tuberculosis nursing homes. 5. Nursing, convalescent or rest homes. *Note #2:* Plans for new construction or material remodeling must be submitted for approval.	1/1/46	Calendar year.	Less than 50 beds, $20. 50–99 beds, $30. 100–199 beds, $40. 200 beds and over, $50.	Yes	Fine up to $100 or imprisonment to 90 days, or both. (Misdemeanor)	Construction. Safety. Fire protection. Communications. Sanitation. Heating. Facilities, equipment. Accommodations, furnishings. Personnel: registered nurse required in homes having more than 6 patients. Records. Reports.	
Application filed on form provided, institution classified as to type, inspection made, provisional permit issued (usually for six months) for operation if facility complies with regulations for particular classification, license granted after provisional period if authorities approve facility. Subsequent inspections permissible. *Note:* Institution classifications: 1. General hospitals, "A" license. (Those meeting standards of American College of Surgeons, American Medical Association or American Osteopathic Association. Must be approved for membership by American Hospital Association or American Osteopathic Association.) 2. General hospitals, "B" license. 3. General limited hospitals. 4. Maternity homes or hospitals. 5. Contagious disease hospitals. 6. Tuberculosis hospitals or sanatoria. 7. Tuberculosis convalescent homes. 8. Convalescent homes. 9. Convalescent homes for care of aged and disabled.	1893 Contagious disease hospitals. 1909 Hospitals, dispensaries, other institutions caring for the sick or injured (including nursing and convalescent homes). 1911 Maternity hospitals.	One year from issuance.	$1 (For original license. No fee for renewal.)	Yes	Fine of $50–$500. (Misdemeanor).	Location (zoning). Fire protection. Sanitation. Accommodations. Admission: maternity cases excluded from units caring for other type cases. Records: narcotics book. Reports: quarterly reports on each patient treated and on all employees. *Convalescent homes* (additional requirements): Admission: convalescent cases only — no tuberculosis, contagious, infectious or pus cases; major surgical cases 10 days and minor surgical 24 hours post operative only; maternity 7 days post partum only. Administration: graduate or practical nurse in charge. *Convalescent homes for care of aged and disabled* (additional requirements): Admission: aged and disabled only — no tuberculosis, contagious or infectious cases. Nursing service: required.	
Application for license filed, institution classified by type, investigation made, license granted if facility complies with regulations for particular classification. Subsequent inspections made periodically. *Note #1:* Institution classifications: 1. Hospitals for chronic and convalescent patients, including nursing homes. 2. Institutions for the mentally ill. 3. Maternity hospitals. 4. All other hospitals. *Note #2:* Local fire marshal cooperates relative to safety and zoning aspects of licensure.	1927 Chronic, convalescent, general hospitals. 1935 Mental hospitals (previously licensed by Governor). 1939 Maternity hospitals (previously licensed by local health officers).	Calendar year.	None, except for private mental hospitals for which fee is $50 per annum.	Yes	Fine up to $1000 or imprisonment to 6 months, or both.	Construction. Safety. Fire protection. Communications. Sanitation. Facilities, equipment. Admission: regulations prescribe type mental patients allowable in non-mental institutions. Personnel: administrative personnel required, nurse ratio to patients. Medical care: conditions under which physician must be present or available. Records. Reports.	

FIGURE 3, SUMMARY OF LICENSURE OF NURSING

STATE	Reference	Regulations Formulated	Coverage of Licensure		State Department Responsible for Inspection, Licensure
			Specifically Included	Specifically Excluded	
Delaware	State of Delaware, Senate Bill No. 94, approved April 24, 1945. Delaware State Board of Health, Regulations Governing the Operation of Sanatoria, Rest Homes, Nursing Homes and Boarding Homes for the Care of the Aged, Infirm, Chronically Ill or Convalescent Persons, approved April 4, 1946.	Yes	Sanatoria, rest homes, nursing homes, boarding homes and related institutions, i.e., "any institution, building or agency in which accommodation is maintained, furnished or offered for any fee, gift, compensation, or reward for the care of aged, infirm, chronically ill, or convalescent persons."	Not specified.	Board of Health.
Illinois	Laws of the State of Illinois, 64th General Assembly, 1945, House Bill No. 252, approved July 17, 1945. Health Department of the State of Illinois, Minimum Standards of Nursing Homes, Aug. 15, 1945.	Yes	"A private home, institution, building, residence or other place which undertakes . . . to provide maintenance, personal care, or nursing for three or more persons who, by reason of illness or physical infirmity, are unable properly to care for themselves."	Federal hospitals. Hospitals operated by the State of Illinois, a political subdivision thereof or municipal corporation therein. Mental hospitals and sanatoria. General and special hospitals. Child care or maternity facilities otherwise licensed by the State. All institutions relying for treatment upon prayer or spiritual means.	Department of Health (Division of Sanitation).
Indiana	Acts of the Legislature of the State of Indiana, 1943, Chap. 158 (Nursing Home Law), as amended by Acts of 1945, Chap. 108, Sec. 17.	Yes	Nursing home for aged, i.e., "any building, structure, institution or place for the reception, accommodation, care or treatment of three or more inmates, aged, sick, infirm, convalescent, invalid, feeble minded, mentally ill, incompetent, decrepit, blind, disabled, injured, infected or chronically ill person, drug addict, dipsomaniac or inebriate, and for which reception, care or treatment a charge is made."	Any "general hospital, home or institution conducted by any religious body or denomination or regularly organized patriotic, fraternal or charitable organization." Homes limited to patients who are Christian Scientists, or who rely in good faith upon Christian Science for healing, are exempted from requirement that a nurse be in charge.	Department of Public Welfare. (Licensure formerly under State Board of Health, 1943–1945).
Maine	State of Maine, Public Laws of 1945, Chap. 355 (An Act Relating to Licensing Hospitals and Related Institutions in the State of Maine). State of Maine Department of Health and Welfare Requirements for Hospital Licensing, Dec. 17, 1945, as amended Jan. 23, 1946.	Yes	General maternity, tuberculosis and mental hospitals and three types of related institutions, i.e., convalescent homes, rest homes and nursing homes. The latter are defined as "institutions or places where care is given to persons because of prolonged physical or mental disability or during recovery from injury or disease. Such care includes any or all of the procedures commonly employed in waiting on the sick."	Hotels and similar places furnishing only board and room. Homes for the aged or blind subject to licensure under other State legislation.	Department of Health and Welfare (Bureau of Health).

HOMES IN SPECIFIED STATES, 1946 — (Continued)

METHOD	Effective Date	Period Covered by License	Fee per Period	License Revoked for Cause	Penalty	Major Requirements for Nursing Homes	Comment
Application filed, inspection made, license granted if facility complies with regulations. Subsequent periodic inspections are made. *Note:* State Fire Marshal and local fire chiefs cooperate relative to fire protection aspects of licensure	6/30/45	Until violation of regulations.	None.	Yes	Fine of $10–$100. (Misdemeanor).	Safety. Fire protection. Sanitation. Heating. Facilities, equipment. Accommodations. Records: register of admissions and individual patient records covering identifying information, diagnosis and data on illnesses.	
Application for license filed investigation made, license issued if institution meets requirements. Subsequent inspections legally allowed. *Note:* State Fire Marshal makes fire and safety inspections.	7/1/45	One year from issuance.	$25 for original license. $5 per renewal.	Yes	Fine of $25–$100, each day's violation being a separate offense. (Misdemeanor).	Construction. Safety. Fire protection. Sanitation. Facilities, equipment. Admission: clinical record and medical recommendations required. Administration: each home must be supervised by a physician. Personnel: number, qualifications. Diet. Records.	State licensure not applicable to any city, village or incorporated town having or enacting a licensure ordinance substantially complying with minimum requirements in State licensure law.
Application for license filed; inspection made by county departments of public welfare, as agents of the State Department of Public Welfare, upon request; license granted if home meets requirements, including those of the State Board of Health and the State Fire Marshal. Subsequent inspections made at discretion of State Department of Public Welfare. *Note #1:* Department of Public Welfare requires written evidence from State fire and public health authorities that applicant complies with rules and regulations of such authorities. *Note #2:* Application for license renewal must be filed 30 days before expiration or is automatically cancelled.	1943	One year from issuance.	Less than 6 beds, $5. 6–10 beds, $10. 11–20 beds, $20. 21 beds and over, $25.	Yes	Fine up to $500 or imprisonment to 6 months, or both. (Misdemeanor).	Safety. Fire protection. Sanitation. Heating, lighting. Facilities. Accommodations. Admission: information on mental and physical condition and on medical and nursing needs of patients required, segregation of young children required. Personnel: nursing care to be provided by at least one qualified nurse. Records: register bearing identifying information and physician's orders for each patient, record of identifying information on each employee.	Falsification of any report on a nursing home by official personnel subject to a fine up to $5000 and imprisonment of one to five years. (Felony).
Application for license filed, institution classified by type, inspection made, license granted if facility complies with regulations for its classification. Subsequent inspections made. *Note #1:* Institution classifications: 1. Hospitals. (a) General. (b) Maternity. (c) Tuberculosis. (d) Mental. 2. Related institutions. (a) Convalescent homes. (b) Rest homes. (c) Nursing homes. *Note #2:* State and local fire authorities assist in safety inspections.	1/1/46	One year from issuance.	$15.	Yes	Fine up to $100 or imprisonment to 90 days. (Misdemeanor).	Fire protection. Sanitation. Heating, lighting. Accommodations. Personnel: at least one registered or practical nurse, physician on call. Records: admission and death records, nursing record on acutely ill, medical record when physician is in attendance. Reports: monthly reports on deaths, report on each communicable disease case.	

FIGURE 3, SUMMARY OF LICENSURE OF NURSING

STATE	Reference	Regulations Formulated	Coverage of Licensure		State Department Responsible for Inspection, Licensure
			Specifically Included	Specifically Excluded	
Maryland	Supplement to Annotated Code of Maryland (1939 edition), Art. 43, Sec. 496A–496K, approved Mar. 8, 1945. Maryland State Board of Health, Standards and Recommendations for Homes for Chronic and Convalescent Patients, Feb. 28, 1946.	Yes	"Any institution which maintains and operates facilities for the care and/or treatment of two or more non-related persons as patients suffering mental or physical ailments, but shall not be construed to include any dispensary of first-aid treatment facilities maintained by any commercial or industrial plant, educational institution or convent." Includes institutions operated by individuals, partnerships, associations, corporations or any State, county or local governmental unit or subdivision thereof.	Federal hospitals. Dispensaries or first-aid treatment facilities maintained by commercial or industrial plants, educational institutions or convents. Homes providing care for only one person at a time.	Board of Health.
Massachusetts	General Laws of the State of Massachusetts (Tercentenary Edition), Chap. 121, Sec. 7, 22-A. The Commonwealth of Massachusetts Department of Public Welfare, Rules and Regulations Relative to Boarding Homes for Aged Persons, Sept. 24, 1942.	Yes	Any "home in which three or more persons over the age of 60 years and not members of his immediate family are, for hire, gain or reward . . . provided with care incident to advanced age." Note: In actual practice many licensed boarding homes for the aged have become convalescent or nursing homes.	Charitable corporations duly incorporated under the State laws which maintain homes or institutions for the care of aged persons.	Department of Public Welfare.
Minnesota	Minnesota Session Laws of 1941, Chap. 549, as amended by Minnesota Session Laws of 1943, Chap. 649, and Minnesota Session Laws of 1945, Chap. 192. Minnesota Department of Health, Licensing Laws and Standards for Hospitals and Related Institutions of Minnesota, 1944. Minnesota Department of Health, Licensing Laws and Standards for Homes for Chronic and Convalescent Patients of Minnesota, May 1, 1944.	Yes	"Any institution, place, building or agency in which any accommodation is maintained, furnished or offered for hospitalization of the sick or injured or care of any aged or infirm persons requiring or receiving chronic or convalescent care." Includes all such institutions operated by State, county or local governmental units.	Homes providing care for only one person at a time. Homes in which persons receiving care are related to the householder by blood or marriage. Hotels and similar places that furnish only board and room, or either. Any institution regularly licensed by the State Director of Social Welfare (day nurseries, child care centers, foster boarding homes, etc.); except those having a dual function, one of which is subject to hospital licensing law (homes for unmarried mothers, infant homes, homes for the aged, child-caring institutions);	Department of Health (Division of Child Hygiene).

HOMES IN SPECIFIED STATES, 1946 — (Continued)

METHOD	Effective Date	Period Covered by License	Fee per Period	License Revoked for Cause	Penalty	Major Requirements for Nursing Homes	Comment
Application for license filed prior to establishment, institution classified by type, investigation made, license granted if institution complies with regulations for its classification. Subsequent inspections made. *Note #1:* Institution classifications: 1. Acute general hospitals. 2. Special hospitals. 3. Homes for chronic and convalescent patients (rest homes, nursing homes, convalescent homes for children, homes for the aged providing chronic and convalescent care). *Note #2:* Facilities must be approved for fire protection by State Fire Marshal or local fire authority.	6/1/45	One year from issuance.	$10.	Not specified	Fine up to $100 for first offense, and up to $500 for each subsequent offense. (Misdemeanor).	Construction. Safety. Fire protection. Sanitation. Facilities, equipment. Accommodations. Admission: medical diagnosis required; communicable disease, maternity and first aid cases excluded. Personnel: each home must have at least one registered or practical nurse. Medical service: each patient must be known to a physician, care to be provided as needed. Records: forms with identifying information, admission and discharge statements, doctors' orders, nurses' notes.	
Application for license filed, license granted at discretion of Department which may visit, inspect and examine accounts of home at any time.	1929	Two years from issuance.	None.	Yes	Fine up to $500 for first offense, imprisonment up to 2 years for each subsequent offense.	Construction. Safety. Fire protection. Sanitation. Storage and use of narcotics, drugs. Admission: excludes prenatal, maternity, contagious disease, mental, alcoholic, narcotic cases. Personnel: resident R. N. recommended. Medical service. Diet. Register of patients.	Unsuccessful attempts by petition have been made, the last in 1945, to legally establish licensure of nursing homes apart from licensure of boarding homes for the aged.
A pplication filed prior to establishment, institution classified by type, investigation made, license granted if facility complies with regulations for its classification. Subsequent inspections made. *Note #1:* Institution classifications: 1. General hospitals. 2. Special hospitals. 3. Homes for unmarried mothers. 4. Maternity homes. 5. Homes for the aged providing chronic or convalescent care. 6. Homes for the chronic and convalescent. *Note #2:* State Fire Marshal reviews application as to fire safety, Division of Social Welfare for compliance with child welfare laws, building and zoning departments of first class cities as to their fields. *Note #3:* Important structural changes require approval.	1/1/42	One year.	Less than 10 beds, $15. 10–49 beds, $20. 50–99 beds, $30. 100 beds and over, $50.	Yes	Fine up to $100 or imprisonment to 90 days. (Misdemeanor).	Location. Construction. Safety. Fire protection. Communications. Sanitation. Heating, lighting. ventilation. Facilities, equipment. Accommodations, furnishings. Admission: on physician's recommendation following examination and diagnosis. Personnel: qualifications. Medical care: medication only on order of legally qualified practitioner, restraint applied only on physician's order and under conditions specified in requirements. Nursing care: in charge of registered, graduate or practical nurse. Records: admission, death, nursing, physicians' orders and nursing personnel records. Reports: on deaths, communicable disease cases.	

FIGURE 3, SUMMARY OF LICENSURE OF NURSING

STATE	Reference	Regulations Formulated	Coverage of Licensure		State Department Responsible for Inspection, Licensure
			Specifically Included	Specifically Excluded	
Missouri	Revised Statutes of Missouri, 1939, Art. 1, Sec. 9735, Chap. 57. Statutes of Missouri, 1941, Senate Bill 142, approved July 28, 1941. State Board of Health of Missouri, Regulations and Code of the State Board of Health Governing the Inspection and Licensing of Convalescent, Nursing, Shelter, or Boarding Homes, 1942 (adopted Dec. 18, 1941).	Yes	Convalescent, nursing, shelter and boarding homes and sanatoria for aged, chronically ill or incurable persons operated by individuals, firms, partnerships, associations or corporations, i.e., " any place in which three or more aged, chronically ill or incurable persons, not related by blood or marriage to the owner, operator or manager . . . are received, kept and provided with food or shelter and care for hire or compensation, however paid . . ."	Homes caring for less than three persons. Homes caring for persons related by blood or marriage to the owner, manager or operator. Homes maintained or operated by the State or any political subdivision thereof. Nursing homes or sanatoria " conducted in conformity with the tenets of any well-recognized church and in which the treatment provided is solely by prayer or spiritual means."	Board of Health.
Nebraska	State of Nebraska, R. S. 1943, Art. 5, Chap. 68. Department of Public Assistance of the Board of Control of the State of Nebraska, Minimum Standards of Licensing Boarding Homes for Aged and Infirm, Dec 1944.	Yes	" Any privately owned or operated place in which three or more adults over 18 years of age, not related by blood or marriage to the owner or manager of said place, who are " . . . receiving Old Age Assistance or Blind Assistance grants . . . " and who are received, kept and provided with food, shelter and care for hire or compensation."	Hospitals registered by the American Medical Association. (This exclusion is based on an administrative resolution.)	Board of Control, Department of Assistance and Child Welfare (Division of Public Assistance).
New Jersey	Revised Statutes of the State of New Jersey, 1937, Title 30, Chap. 11. State of New Jersey Department of Institutions and Agencies, Minimum Standards for Nursing Homes, Jan. 1941.	Yes	All homes providing care, treatment and nursing service for two or more persons at a time who are ill with disease or are crippled, infirm, or in any way afflicted. *Note:* Since 1906 New Jersey has licensed mental hospitals. However, the standards applicable are specific for this type of institution.	" Any hospital, home or institution conducted by or for the members of any religious body or denomination or regularly organized fraternal or charitable association." Homes providing care for only one person at a time.	Department of Institutions and Agencies.

HOMES IN SPECIFIED STATES, 1946 — (Continued)

METHOD	Effective Date	Period Covered by License	Fee per Period	License Revoked for Cause	Penalty	Major Requirements for Nursing Homes	Comment
Application filed on form provided, inspection made, license issued if facility complies with regulations. Subsequent inspections, at least annually, are mandatory by law. *Note:* Where local fire inspection service is available, applicant must obtain a certificate of compliance from such authorities.	Feb. 1942	One year from issuance.	10 beds or less, $5. Over 10 beds, $10.	Yes	Fine up to $25, each week of non-compliance being a separate offense. (Misdemeanor).	Location. Construction. Safety. Fire protection. Sanitation. Heating, lighting, ventilation. Facilities, equipment. Accommodations, furnishings. Administration: in charge of a responsible, qualified attendant. Admission: excludes contagious disease cases in communicable state, maternity cases unless home is specifically qualified, children unless special facilities are available. All patients examined, recommendations for care made by supervising physician. Medical and nursing care: supervision by qualified physician who (1) visits at least twice monthly and on call, (2) is responsible for adequacy and direction of nursing service subject to approval of the State Board of Health, (3) makes written recommendations to superintendent for changes to insure adequate medical care (copy to Board of Health) and notifies Board of any failure of home to comply. Records: identifying information, clinical record, doctors' orders on each patient, record of physical examination of each employee, daily records of food served. Reports: monthly to Board of Health.	
Application for license filed, investigation made, license granted if requirements are met. Subsequent inspections permissible. *Note:* Approval of State Fire Marshal and State Health Department required.	1/1/44	One year from issuance.	$1.	Yes	Fine up to $100 or imprisonment to 30 days, or both. (Misdemeanor).	Safety. Fire protection. Sanitation. Facilities. Accommodations. Admission: physical examination and medical recommendations required. Personnel: physical condition, adequate number. Diet. Records.	
Application for license filed, accompanied by the written approval of local zoning, building, sanitation and fire authorities; investigation made, followed by a six-month probationary period of operation; license then granted if institution complies with published standards. A continuing supervisory relationship is maintained with each nursing home, with visitations at not less than quarterly intervals and more often if necessary. *Note:* All plans for structural changes must be submitted for approval before construction is undertaken.	1927	One year from issuance.	$25.	Yes	Fine of $500 or imprisonment for 6 months, or both.	Construction. Safety. Fire protection. Sanitation. Facilities, equipment. Accommodations, furnishings. Admission: recent medical diagnosis required, no admits on life basis. Personnel: registered nurse required, ratio of nurses to patients. Medical and nursing care: home must designate physician available for emergency, patients must be seen periodically by physician. Records: patients' register, physicians' register, physicians' order book, narcotic book, nursing record.	

FIGURE 3, SUMMARY OF LICENSURE OF NURSING

STATE	Reference	Regulations Formulated	Coverage of Licensure		State Department Responsible for Inspection, Licensure
			Specifically Included	Specifically Excluded	
North Dakota	State of North Dakota, 1945 Session Laws, Chap. 280, approved Mar. 10, 1945. Public Welfare Board of North Dakota, Standards for Homes for the Aged and Infirm, Oct. 15, 1945.	Yes	Boarding homes for the aged and infirm, i.e., "any place, not licensed by the State Department of Health, operated by any person, institution, organization or private or public corporation, in which three or more adults who are aged or infirm and not related by blood or marriage to the owner or manager of said place, are received, kept and provided with food, shelter and care for hire or compensation." *Note:* In the absence of a law specifically licensing nursing homes, and since many provide care to three or more aged persons, a number of such institutions are licensed under the "boarding homes for the aged" legislation.	Facilities licensed by the State Department of Health. Homes caring for less than three adults. Homes caring for persons related by blood or marriage to the owner or manager.	Public Welfare Board.
Ohio	General Code of Ohio, Sec. 6289–1 to 6289–11, Sec. 1890–19 to 1890–21. Department of Public Welfare of the State of Ohio, Executive Order No. 20. Ohio State Department of Public Welfare, Rules and Regulations for Rest Homes, Convalescent Homes, and Boarding Homes for the Aged and Physically Infirm, Oct. 1942.	Yes	All rest homes, convalescent or boarding homes for the aged or mentally or physically infirm, i.e., "any place of abode, building, institution, residence or home used for the reception and care, for a consideration, of three or more persons who, by reason of age or mental or physical infirmities are not capable of properly caring for themselves, or who are 65 years of age or upwards," and who are not related to the operator by blood or marriage.	Institutions or nursing homes for treatment of mental disease which are classified as such under State law and which come within the standards prescribed by the Division of Mental Diseases of the State Department of Public Welfare for such institutions and homes.	Department of Public Welfare.
Oklahoma	Oklahoma Statutes, 1945 Supplement, Title 63, Chap. 1, Sec 1.3, Title 63, Chap. 7A, Sec 326.1 to 326.13. Oklahoma State Department of Health, License Laws and Standards for Hospitals and Related Institutions of Oklahoma, May 15, 1946.	Yes	"Any hospital, sanatorium, rest home, nursing home or other institution for the hospitalization and/or care of the sick or injured or care of any human beings requiring or receiving chronic or convalescent care" which is established, conducted or maintained by an individual, partnership, association, corporation or any State, county or local governmental unit or any division, department or agency thereof. *Note:* Includes private homes boarding two or more aged and infirm persons who are receiving chronic or convalescent care.	Federal hospitals. State mental hospitals. Hotels or other similar places furnishing only board and room. Homes in which persons receiving care are related to operator by blood or marriage. Homes caring for only one person at a time, except maternity homes receiving more than one person in a six month period. Homes or institutions for aged and infirm persons which do not provide chronic or convalescent care for two or more patients at one time. First aid stations and emergency care facilities not providing hospitalization.	Department of Health.

HOMES IN SPECIFIED STATES, 1946 — (Continued)

METHOD	Effective Date	Period Covered by License	Fee per Period	License Revoked for Cause	Penalty	Major Requirements for Nursing Homes	Comment
Application filed on form provided, inspection made, license granted if home complies with regulations. Subsequent inspections made annually for renewal of license. *Note #1:* Upon request of Public Welfare Board, the State Department of Health and the State Fire Marshal cooperate in the licensing procedure. *Note #2.* Board advocates that establishment of a home "in any particular community should be planned only after a study of the number and type of persons needing such care has been made." *Note #3:* Upon request, Board will furnish information as to additional desirable standards even though not required as a condition of licensure; and will assist in studies relative to determining the need for a new home.	1/1/46	Calendar year.	None.	Yes	Fine up to $100 or imprisonment to 30 days, or both. (Misdemeanor).	Location. Construction. Safety. Fire protection. Communications. Sanitation. Facilities, equipment. Accommodations, furnishings. Admission: physical examination required. Personnel: ratio of employees to guests, annual physical examination. Diet. Freedom of guests to attend church, movies, go on walks, etc., when compatible with physical condition. Records: register of identifying information on each guest; record of all agreements and contracts between the home and guests. *Note:* Public Welfare Board is hopeful that, as it gains experience in licensing and homes become accustomed to regulations, standards of care and of licensing can be improved.	A bill was introduced, but defeated, in the 1945 Legislative Assembly establishing comprehensive licensure of hospitals, maternity homes and nursing homes.
Application for license filed, investigation made, license granted if institution complies with rules and regulations. Subsequent inspections permissible. *Note:* Upon request of Department of Public Welfare, the State Departments of Industrial Relations and Health and the State Fire Marshal cooperate in making inspections.	1/1/42	One year from issuance.	$5.	Yes	Fine up to $25 for each offense, each day's violation being considered a separate offense. (Misdemeanor).	Location. Construction. Safety. Fire protection. Sanitation. Facilities, equipment. Accommodations. Admission requirements. Personnel (adequacy). Diet. Records: admission records, physicians' order book (inc. record of treatment), narcotic record Reports.	
Verified application filed on form provided (for both licensure and renewals), institution classified as to type, investigation made, license granted if institution complies with regulations for particular classification. Subsequent inspections made periodically. *Note #1:* Institution classifications: 1. General hospitals. 2. Special hospitals. 3. Maternity homes 4. Homes for unmarried mothers. 5. Homes for chronic or convalescent patients. 6. Homes for aged providing chronic or convalescent care. *Note #2:* As one prerequisite of licensure, State Fire Marshal must approve institution as to fire protection. *Note #3:* Plans for new construction or material remodeling must be approved.	7/1/46	Calendar year.	Less than 50 beds, $10. 50–99 beds, $15. 100–199 beds, $20. 200 beds and over, $25.	Yes	Fine up to $100 or imprisonment to 90 days, or both. (Misdemeanor).	Location (zoning). Construction. Safety. Fire protection. Communications. Sanitation. Heating, lighting, ventilation. Facilities, equipment. Accommodations, furnishings. Character reference on applicant (age, name, reputation). Admission: homes for adults may not admit children, physical examination required. Personnel: physician on call, R. N. or practical nurse ratio to patients. Medical care: medication and treatment on physician's order only, circumstances under which restraints may be used. Nursing service: registered or practical nurse must be in charge. Records: clinical records, physician's orders. Reports: death certificates, communicable disease cases, annual reports.	

FIGURE 3, SUMMARY OF LICENSURE OF NURSING

STATE	Reference	Regulations Formulated	Coverage of Licensure		State Department Responsible for Inspection, Licensure
			Specifically Included	Specifically Excluded	
Pennsylvania	Commonwealth of Pennsylvania, Pamphlet Laws, No. 510 (June 12, 1931); as amended by P. L. 1075, No. 259 (May 26. 1933); P. L. 438 (June 19, 1939); and Act of the General Assembly No. 67 (June 13, 1941). Rules and Regulations of the Department of Welfare of the Commonwealth of Pennsylvania Regulating Certain Private Nursing Homes and Private Hospitals (Bulletin 56), approved by State Welfare Commission, 1933.	Yes	Private nursing homes and hospitals operated for profit by individuals, copartnerships, associations or corporations " to give care to persons requiring care, treatment or nursing by reason of sickness, injury, infirmity or other disability."	Non-profit hospitals and nursing homes. State and state-aided institutions. Institutions licensed by the Department of Welfare under other statutes.	Department of Welfare.
Rhode Island	Public Laws of Rhode Island, Jan. 1929, Chap. 1413, as amended by Public Laws of 1938, Chap. 374. Rhode Island State Department of Social Welfare, to Owners and Operators of Homes for Aged or Convalescent Persons (a statement of minimum standards and regulations).	Yes	Any home for aged or convalescent persons operated by an individual, unincorporated society or corporation in which two or more persons, unrelated to the operator, are given care. This applies to chronic or acute illness and includes all types of supervision or personal assistance rendered the physically infirm.	Homes caring for relatives. Institutions receiving aid from a town, city or the State. Institutions with special charters. Charitable institutions established in the State at the time of passage of the original licensure legislation (Jan. 1929). Homes caring for contagious and infectious disease cases. *Note:* Licenses are not ordinarily granted to homes already licensed as nursery or maternity homes.	Department of Social Welfare.
South Dakota	Laws of South Dakota, 1945, Chap. 108, approved Mar. 1, 1945.	No	All hospitals, sanatoria, maternity homes, boarding homes and other related institutions operated by individuals, partnerships, associations or corporations, i.e., any " institution, place, building or agency in which any accommodation is maintained, furnished or offered for the hospitalization of the sick or injured, or for the care of any aged or infirm person requiring or receiving chronic or convalescent care," . . . or . . . " in which, within a period of six months, more than one woman, during pregnancy, or during or after delivery . . . (is) kept for care or treatment," or which has two or more infants under care unattended by parents or guardians.	State institutions, children's homes, associations or institutions caring for children which are incorporated under State law. Homes caring for individuals related by blood or marriage to the proprietor or operator. Institutions conducted in accordance with the practices and principles of the Church of Christ, Scientist, are required to conform only to regulations relative to sanitation, safety and cleanliness. Hotels, restaurants, lodging or rooming houses, boarding houses or similar places proving only to lodging or board, or both.	Board of Health.
Texas	Texas State Legislature, House Bill No. 127, 1945 (approved).	No	Convalescent homes caring for aged, dependent patients, i.e., " any place or establishment where three (3) or more pension or old age assistance recipients are housed for hire or profit."	Hotels.	Department of Public Health

HOMES IN SPECIFIED STATES, 1946 — (Concluded)

METHOD	Effective Date	Period Covered by License	Fee per Period	License Revoked for Cause	Penalty	Major Requirements for Nursing Homes	Comment
Application filed on form provided, investigation made, license granted if facility complies with rules and regulations. Subsequent inspections permissible. *Note:* State Departments of Health, Labor and Industry and fire authorities cooperate in licensing process.	Not Specified (Legislation approved in 1931).	One year from date of issuance.	$15.	Yes	Fine up to $1000 or imprisonment to one year, or both.	Fire protection. Sanitation. Heating. Facilities, equipment. Accommodations. Reference on applicant. Admission: chronically ill, aged and convalescent patients accepted; physical examination required at admission; communicable disease, tuberculosis cases accepted if no non-infectious cases are under care; mental cases admissible if home has license therefor; home caring for children cannot admit adults. Patient admissible for life care only if home proves ability to fulfill contract. Personnel: 5 bed or 8–10 ambulatory patients per nurse (or attendant). Medical care: physician on call. Records: register of identifying information on each patient; temperature charts, nurses' records and doctor's orders on each acutely ill patient.	
Application filed on form provided, investigation made, license granted if facility complies with regulations. Subsequent inspections made. *Note:* Issuance of license contingent upon approval of local zoning board, building inspector and fire authority.	July, 1929.	Two years from issuance.	None.	Yes	Fine of $25–$100 for each month of operation without a license, or for each refusal to permit inspection.	Safety. Fire protection. Sanitation. Lighting, ventilation. Facilities, equipment. Accommodations. Reference on applicant. Diet. Records: dietary. Reports: statistical report filed annually with licensing agency.	File of licensed homes and existing vacancies maintained by the Department is available to qualified agencies placing clients. Placement service available to physicians and individuals through Department.
Regulations not yet formulated. However, law indicates that applications will be filed, inspections made, and licenses issued if the facility complies with official requirements. Subsequently, licensed facilities are to be inspected periodically.	Pending referendum. See last column.	One year ending each June 30.	Less than 50 beds, $10. 50–99 beds, $15. 100–199 beds, $20. 200 or more beds, $25.	Yes	Fine up to $100 or imprisonment to 90 days. (Misdemeanor).	Formulation of regulations pending referendum. See last column.	Law as approved was to have been effective July 1, 1945. However, since a referendum petition was filed, the law will be submitted to the vote of the people in the general election of November, 1946.
Regulations not yet formulated. However, law indicates that applications will be filed on form provided, investigations made, and license granted if the facility complies with official requirements. Subsequent inspections to be made at least quarterly.	Pending appropriation. See last column.	Not specified.	$1.	Yes	Fine of $25–$200, each day's violation being a separate offense. (Misdemeanor).	Regulations in process of formulation. See last column.	Since the 1945 Legislature failed to appropriate funds for operation, licensure did not become effective following approval of legislation, as provided in the law.

SUPPLEMENTARY MATERIAL

A STUDY OF NURSING HOMES IN NEW YORK STATE (1943)*

The Nursing Home Study made by the New York State Department of Social Welfare in 1943 was begun in April, most of the data were collected in May and June and the tabulations completed by October of the same year. The inquiry was confined to (1) those recipients of public assistance who were under care at that time in nursing homes in selected areas of the State and (2) the homes in which this care was being provided.

The following presentation consists of two parts, (1) the tabular data collected in 1943 by the Department of Social Welfare, as interpreted by the New York State Health Preparedness Commission;[1] and (2) the subsequent action taken by the Department, as a result of the study, to improve conditions insofar as possible during the necessary period of long range planning.

PURPOSE OF THE STUDY

The study was made because the local departments of public welfare, endeavoring to provide suitable care for ill recipients of public assistance who could not be cared for in their own homes and who were not appropriate cases for general hospital service, were using "nursing homes" and requesting State reimbursement for this expenditure. It was, therefore, necessary to secure information on the nursing homes and define the problem.

From 1931 to 1937 the Temporary Emergency Relief Administration of New York State regarded care in nursing homes as an extension of hospital care and therefore not reimbursable. A similar view was taken by the successor to the TERA, the Bureau of Public Assistance of the State Department of Social Welfare, which began operations July 1, 1937. Overcoming this technicality, some local departments of public welfare paid for such care by allowing a client two grants, one for board and lodging and the other for nursing care. The sum of the two grants aggregated the nursing home fee, each of the separate items being reimbursable from the State. The technicality and the practice had to be resolved.

Other factors were encouraging and even necessitating the use of nursing homes for appropriate public assistance cases. The advent of Old Age Assistance in 1935 made it possible to grant public assistance to the aged living in their own homes, obviating the economic necessity of these individuals entering the county and city public homes as a source of shelter and board. When such recipients became ill, could not be cared for at home and were not appropriate cases for general hospital service, some place of care had to be found, preferably where care would be reimbursable by the State and Federal governments. The result was an accelerated trend toward nursing home care. Even if the client had preferred care in the public home infirmary, many localities would not have encouraged such a placement because the capacities of the infirmaries were limited and payment for care therein was not, and is not, reimbursable from State and Federal sources.

Many general hospitals were loathe to admit and retain the long-term cases of chronic illness requiring nursing care rather than continuous, active medical service. This tendency was more pronounced in the teaching hospitals interested in admitting diverse types of cases for teaching purposes. In addition, the rising rates in general hospitals deterred placement when active medical service was not a necessity.

Concurrent with these factors, there was a growing ing sense of local responsibility for providing prompt and adequate medical service to recipients of public assistance and an increasing realization of the need for more complete local medical care programs. In the depression years of the 1930's the Federal Emergency Relief Administration, through allotments to the states, provided funds for medical care for relief clients. In the year following the termination of the FERA, expenditures for medical care increased in New York State, the reverse of the trend in most other states. Furthermore, many county and city departments of public welfare in the State developed Local Medical Care Plans with the assistance and approval of the State Department of Social Welfare, thus further evidencing a sense of responsibility for providing more adequate medical care for their clients.

METHOD

Since no definition of "nursing home" was applied for the purpose of the study, the homes included are those which the local departments of public welfare considered as being "nursing homes."

The information sought was of three types. (1) Information regarding the policies of the local departments of public welfare relative to the nursing homes used by them was collected jointly by the area medical social workers and the inspectors of welfare institutions and was recorded on Form NH-1. (2) Data on public assistance patients receiving care in nursing homes were collected by the area medical social workers and recorded on Form NH-2. (3) Data on the nursing homes were collected by the inspectors of welfare institutions and recorded on Form NH-3.

The sources of information were (a) the case records and medical records, where the latter existed, of the nursing home patients on file in the local departments of public welfare; (b) the records of the patients on file in the nursing homes, if such records existed; and (c) conferences and discussions with the local public welfare and nursing home personnel.

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* This material was previously published in mimeographed form by the Commission in May, 1946.

[1] The data were collected and tabulated but neither interpreted nor published by the Department of Social Welfare at the time of the study.

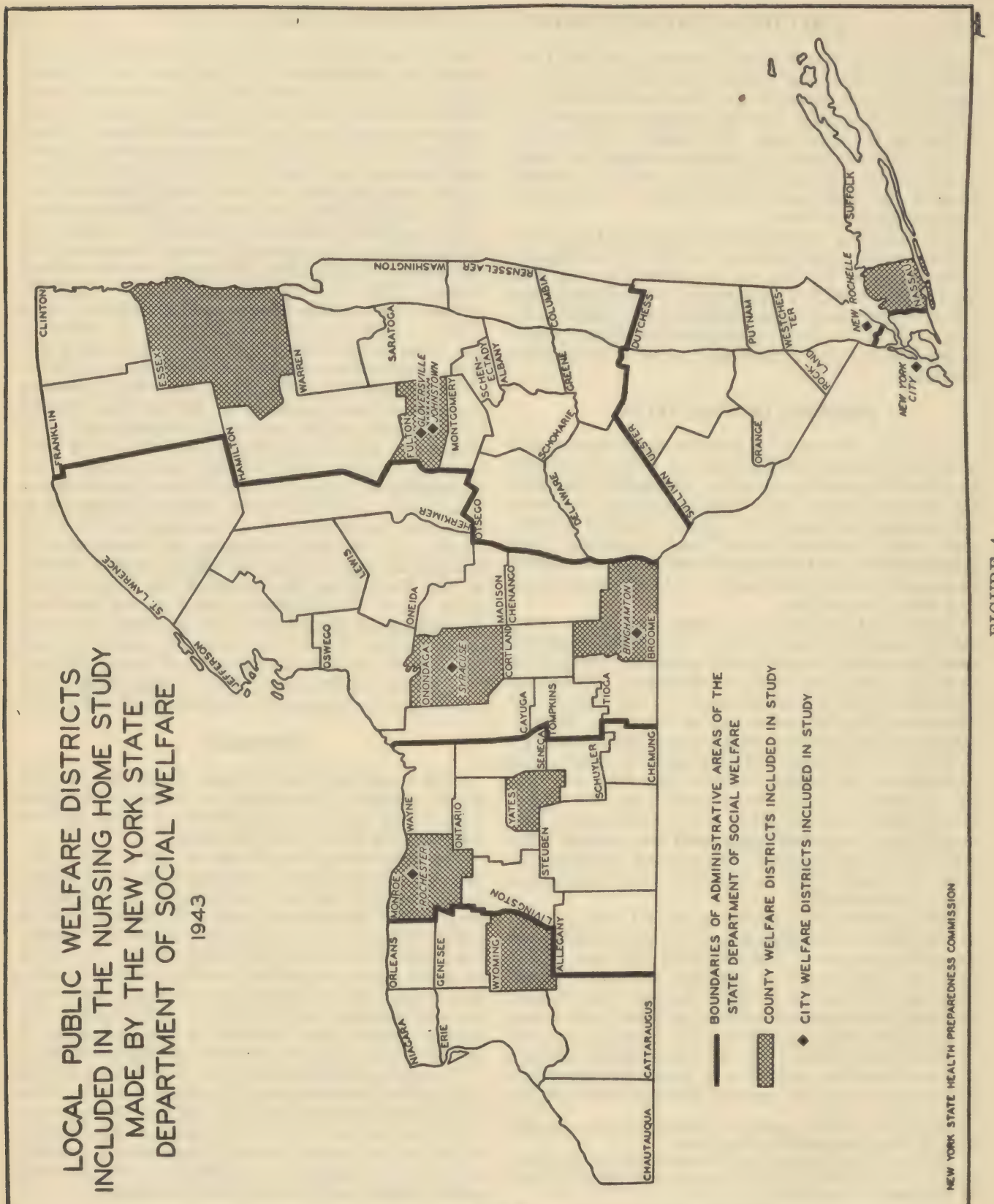
LOCAL PUBLIC WELFARE DISTRICTS
INCLUDED IN THE NURSING HOME STUDY
MADE BY THE NEW YORK STATE
DEPARTMENT OF SOCIAL WELFARE
1943
CLINTON
FRANKLIN
ESSEX
WARREN
SARATOGA
WASHINGTON
RENSSELAER
COLUMBIA
DUTCHESS
PUTNAM
WESTCHESTER
ROCKLAND
NEW ROCHELLE
SUFFOLK
NASSAU
NEW YORK CITY
HAMILTON
FULTON
GLOVERSVILLE
JOHNSTOWN
MONTGOMERY
SCHENECTADY
ALBANY
GREENE
SCHOHARIE
DELAWARE
ULSTER
SULLIVAN
ORANGE
HERKIMER
OTSEGO
ST. LAWRENCE
LEWIS
JEFFERSON
OSWEGO
ONEIDA
MADISON
CHENANGO
ONONDAGA
SYRACUSE
CORTLAND
BINGHAMTON
BROOME
CAYUGA
TOMPKINS
TIOGA
SENECA
SCHUYLER
CHEMUNG
YATES
WAYNE
ONTARIO
MONROE
ROCHESTER
STEUBEN
LIVINGSTON
ALLEGANY
WYOMING
ORLEANS
GENESEE
NIAGARA
ERIE
CHAUTAUQUA
CATTARAUGUS
BOUNDARIES OF ADMINISTRATIVE AREAS OF THE STATE DEPARTMENT OF SOCIAL WELFARE
COUNTY WELFARE DISTRICTS INCLUDED IN STUDY
CITY WELFARE DISTRICTS INCLUDED IN STUDY
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 4

The welfare districts included in this study were selected for study, as shown in Figure 4, page 108,

1. Welfare districts covered by local laws relating to inspection and licensing of nursing homes. *Example:* Nassau County, where inspection and licensing is a County Health Department function.
2. Welfare districts which have established criteria and detailed rules and regulations for the use of nursing homes. *Example:* Monroe County.
3. Welfare districts covered neither by law nor by locally developed and written policies and procedures pertaining to nursing homes, and which may or may not have a county home infirmary. *Example:* Wyoming County.

On the basis of these criteria 13 welfare districts were selected for study, as shown in Figure 4, page 108, and Table 33.

TABLE 33. *Welfare Districts Selected for Study*

WELFARE DISTRICT	Has Licensure of Nursing Homes		Has Written Criteria		Has County Home Infirmary	
	Yes	No	Yes	No	Yes	No
Binghamton City	....	x	....	x	x[1]	....
Broome County	....	x	....	x	x	....
Essex County	x[2]	....	....	x	x	....
Fulton County	....	x	....	x	....	x
Gloversville City	....	x	....	x	....	x
Johnstown City	....	x	....	x	....	x
Monroe County	....	x	x	....	x	....
Nassau County	x	....	....	x	x	....
New Rochelle City	x	....	....	x	x[3]	....
Onondaga County	x[4]	....	....	x	x	....
Wyoming County	....	x	....	x	....	x
Yates County	....	x	x	....	....	x
New York City	x	....	....	x	x[5]	....

[1] Uses Broome County Infirmary.
[2] Applicable to proprietary nursing homes caring for tuberculosis cases in the Consolidated Health District of Saranac Lake and Harrietstown.
[3] Uses Westchester County Infirmary.
[4] In Syracuse City only.
[5] Uses Welfare Island Institution.

The number of public assistance cases receiving nursing home care was first ascertained for each of the welfare districts, after which the exact number of cases to be studied was determined. Where less than 25 recipients of public assistance were in nursing homes, all such cases were studied; where 25-50 recipients were in nursing homes, 25 cases were studied; where 50–100 recipients were in nursing homes, 35 cases were studied; where 100 or more recipients were in nursing homes, 50 cases were studied; and in New York City the cases were studied in several welfare districts within the city by this ratio method. Care was exercised to select cases under care in various types and sizes of homes and receiving the different forms of public assistance. Every nursing home in a welfare district was studied which provided care for one or more public assistance cases selected for study. The numbers of cases and nursing homes studied are shown in Table 34.

TABLE 34. *Number of Patients and Nursing Homes Studied*

WELFARE DISTRICT	Public Assistance Recipients in Nursing Homes		Nursing Homes Used by Local Welfare Depts.	
	Total	Included in Study	Total	Included in Study
Total	802	322	148	109
Upstate	593	270	111	93
Binghamton City	38	25	8	8
Broome County	14	14	6	3
Essex County	5	5	3	3
Fulton County	70	35	24	19
Gloversville City	3	3	3	[1]
Johnstown City	2	2	2	[1]
Monroe County	147	50	14	14
Nassau County	157	50	14	13
New Rochelle City	39	26	8	6
Onondaga County	108	50	19	17
Wyoming County	2	2	2	2
Yates County	8	8	8	8
New York City	209	52	37	16

[1] Uses homes listed under Fulton County.

POLICIES IN REGARD TO NURSING HOMES

Definitions The definitions of nursing homes, used by the local departments of public welfare, ranged from vague statements that a nursing home was one "approved by the attending physician for the individual patient," or one capable of giving "more personal attention than is required in a boarding home," to elaborate statements in welfare districts where nursing homes are licensed.[2] This ambiguity was partly due to the State Department of Social Welfare's not yet having formulated a definition for local use. Moreover, during the course of the study, the Department had carefully avoided assisting the communities in this regard lest there be a tendency to classify "nursing homes" as "institutions," care in the latter not being reimbursable from State and Federal funds.

Only a few welfare districts had a written definition of "nursing home" for local administrative use and in most the definition was a verbal expression of a staff member. Yet these locally conceived definitions indicated an attempt to conform to certain philosophies. For example, some definitions stated that nursing homes could not be used for "patients under 16 years of age," obviously an application of a prohibition in the State Child Welfare Law. And again, some definitions stated that the patient "should not be related to the proprietor by blood or marriage," an application of an unwritten policy that public welfare departments did not expect to pay relatives for the care of close kin.

Criteria The criteria applied by the local departments in selecting nursing homes for recipients of public assistance ranged from the approval of "any home satisfactory to the attending physician," or one having the "essential requisites for family life," to a long list of qualifications. Those in one county covered safety, sanitation, ventilation, lighting, heating, plumbing, separate rooms, adequacy of linen, eating utensils, diet, storage of drugs and narcotics, supervision, records, and so forth.

Although there was no general uniformity of criteria among the welfare districts studied, it was recognized that placements in nursing homes should be based on medical advice.

PUBLIC ASSISTANCE PATIENTS IN NURSING HOMES

Type of Patients Analysis of the data on 322 of the 802 public assistance recipients (39 per cent) receiving care in nursing homes showed that one-sixth were in New York City. Although there was only a slight preponderance of females in this New York City population, the ratio of females to males in upstate New York was two to one. See Table 35.

TABLE 35. *Number of Patients Studied, by Sex*

AREA	Total	Male	Female
Total	322	116	206
Upstate	270	93	177
New York City	52	23	29

A number of factors, and combinations thereof, might explain this disparity. The average life span of women exceeds that of men. An effort may have been made to place women in more desirable situations. Since the male population in the public homes in the State was two and a half times that of the female population at the end of 1943, there might have been a tendency to place men and not women in such public institutions.[2] Nine of every ten patients were 55 years old and over and most were over 65 years of age. There was little difference between the age distribution in New York City and upstate New York. See Table 36.

Ninety per cent of the cases in upstate New York and 77 per cent of those in New York City were public charges prior to admission to the present nursing home, the remaining cases having become a public responsibility either at the time of or following admission.[3] Thus the local public welfare officials were a party to, or were aware of, the admissions in a large proportion of the cases. The lower proportion of public charges in New York City is largely due to the city's policy of not accepting cases for assistance for "medical care only." When the study was being made, over two-thirds (223) of the patients were receiving Old Age Assistance, a reasonable number Home Relief (86) and only a very few Aid to Blind (11) and Child Welfare (3) funds. Even though three patients were Child Welfare cases it should be noted that the placement of children in nursing homes was actually not allowable under law.

TABLE 36. *Number of Patients Studied, by Age*

AGE GROUP	Total		Upstate		New York City	
	No.	Per Cent	No.	Per Cent	No.	Per Cent
Total	322	100.0	270	100.0	52	100.0
Under 20 years	4	1.2	4	1.0	....	.....
20 through 44 years	16	5.0	12	4.4	4	7.6
45 through 54 years	11	3.4	11	4.0	....	.....
55 through 64 years	36	11.2	29	10.7	7	13.5
65 through 74 years	87	27.0	75	27.8	12	23.1
75 years and over	167	51.9	138	51.7	29	55.8
Unknown	1	0.3	1	0.4	....	.....

TABLE 37. *Number of Patients Studied, by Type of Assistance*

TYPE OF ASSISTANCE	Total	Upstate	New York City
Total	322	270	52
Old Age Assistance	223	185	38
Aid to the Blind	11	8	3
Home Relief	85	74	11
Child Welfare	3	3	....

Medical Classification All but a few of the diagnoses of the patients had been made either by attending physicians (60 per cent) or by hospitals (30 per cent). The dominant conditions were cardio-vascular, neurological and psychiatric, rheumatic, metabolic and glandular. Among the 31 patients under 55 years of age the most

[2] New York State Department of Social Welfare, Bureau of Research and Statistics, *County, City and Town Public Homes in New York State, 1943.*

[3] The term "public charge" covers all persons whose care is provided wholly or partially at public expense. It includes all public assistance cases (Old Age Assistance, Aid to the Blind, Aid to Dependent Children, Home Relief), child welfare service cases, children cared for in institutions by public funds, and individuals in public homes. At the time of the study, Aid to Dependent Children funds could not be used to provide nursing home care for adults in ADC families.

frequent diagnoses were those of rheumatic, metabolic and glandular diseases (7), cardiovascular diseases (7), neurological conditions (5), infectious diseases (3) and neoplasms (2). One-quarter of the patients, mostly over 70 years old, showed evidence of such mental aberrations as senility, forgetfulness, confusion and childishness. Half of these conditions had been classified on the basis of the observations of physicians, while the remainder were noted by hospitals, social investigators and lay observers. See Table 38.

TABLE 38. *Number of Patients Studied, by Diagnosis*

DIAGNOSIS	Number	Per Cent
Total	322	100.0
Cardio-vascular disease	129	40.1
Neurological and psychiatric conditions	55	17.1
Rheumatic disease, disorders of metabolism, endocrine glands, vitamin deficiency	42	13.1
Traumatic conditions and poisoning	20	6.2
Neoplasms	16	5.0
Diseases of the eye and ear	12	3.7
Diseases of the digestive system	9	2.8
Diseases of the uro-genital system	8	2.4
All other	22	6.8
Information inadequate to classify	9	2.8

Approximately one-third (30 per cent) of the patients were bedridden; one-half (46 per cent), although not bedridden, required considerable care from others; and one-quarter (24 per cent) were able to care for themselves. These classifications on physical condition were made by the individuals indicated in Table 39.

TABLE 39. *Persons Classifying Degree of Mobility of Patients*

PERSONS CLASSIFYING	Number of Patients
Total	322
Social investigator	153
Physician	55
Medical social investigator	37
Nursing home proprietor	26
Nurse	19
Hospital	16
Hospital medical social worker	3
Other	5
No report	8

However, the amount of care which the patient requires is more important than whether he is bedridden or ambulatory. This requirement, in addition to his physical and mental condition, is one of the factors which determines the ability of the patient's own home to provide proper care, the willingness of a nursing home to admit him and the rate which the nursing home will charge. Similarly, the amount of care required has a bearing on whether or not the patient can eventually be discharged from the nursing home and resume a relatively normal life in the community. See Table 40.

TABLE 40. *Diagnostic Classifications of Patients, by Extent of Care Needed*

DIAGNOSTIC CLASSIFICATION	Total Patients	Physical Condition		
		Bedridden	Needing Considerable Care [1]	Able to Care for Self
Total	322	96	148	78
Cardio-vascular diseases	129	35	71	23
Neurological and psychiatric conditions	55	21	19	15
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies	42	15	21	6
Traumatic conditions, poisoning	20	6	11	3
Neoplasms	16	7	4	5
Diseases of the eye and ear	12	4	4	4
Diseases of the digestive system	9	2	4	3
Diseases of the uro-genital system	8	2	3	3
Blood, splenic, lymphatic diseases	5	1	2	2
Infectious diseases	4	..	..	4
Diseases of the respiratory system	3	..	..	3
Peritoneal and other abdominal conditions, hernia	2	..	2	..
Non-traumatic diseases of bones and organs of movement	2	..	..	2
Diseases of skin, cellular tissue	1	..	1	..
All other	5	2	3	..
Information inadequate to classify	9	1	3	5

[1] Not bedridden, but requiring considerable care from others.

Supervision Although a great majority of the patients (85 per cent) were reported as receiving medical or medical plus nursing supervision, the degree and quality thereof is unknown. Yet such supervision is an important factor in achieving complete convalescence, attaining stability in the physical condition, obviating "dumping" in nursing homes and having a flow of population in the homes. See Table 41, page 112.

TABLE 41. *Sources of Supervision of Patients*

SUPERVISION	Number	Per Cent
Total	322	100.0
Medical	183	56.8
Medical and nursing	91	28.3
Nursing	5	1.5
Parole	1	0.3
None	35	10.9
No report	7	2.2

Prior Institutional Care

Prior to making the study the State Department of Social Welfare was under the impression that patients admitted to nursing homes practically always went directly following hospitalization. This was not the case. Two-thirds of the upstate and two-fifths of the New York City patients had no history of hospital or institutional care *immediately preceding* admission to the present nursing home. Furthermore, one-third (105) of the upstate patients in the nursing homes had no previous history of institutional care, although the remainder (165) had at some time been in general hospitals. The situation was similar in New York City where 40 per cent (22) had had no previous institutional care and the remainder (30) usually had had care at some time in general hospitals.

Since these cases were largely those of aged persons, their medical conditions might not have required hospital service or they might have been unwilling to avail themselves of modern medical services. Whatever the reason, it seems evident that the patients were in the nursing homes for custodial, long-term nursing or terminal care rather than for convalescent care.

Reasons For Placement

A review of a random sample of cases included in the study showed that a number of placements were necessitated by a breakdown of family life and by the current industrial-economic situation. The following are examples:

1. An ill and lone person, whose spouse had recently died, was dependent, subject to rapid deterioration and in need of nursing care.
2. A wife, busily caring for six small children, was unable to give adequate nursing care to her ill husband.
3. An ill and lone person had refused care in a county home infirmary, yet required nursing service.
4. The adults of a family group were employed in war industries, could not remain at home to nurse an older member and were without sufficient funds to employ a nurse or pay for care in a nursing home without public assistance.

As shown in Table 42, one-half of the 322 patients were placed in nursing homes solely for medical reasons, one-quarter because of interrelated medical and social reasons and another quarter for social reasons only.

Social factors were inherent in the majority of reasons for placement in almost half the cases falling into the five most frequent diagnostic classifications. Since these diagnoses are often indicative of a need for long-term custodial, nursing or terminal care, this correlation is logical. During an acute illness or an acute exacerbation of a chronic illness, medical services and judgments are primary concerns of both the physician and the patient. However, as the need for this more dramatic type of care lessens and is followed by a tedious, prolonged period of convalescence or nursing care, the physician and patient become increasingly aware of the latter's economic situation, morale, home environment and rapport with the persons in his immediate environment. It is a shifting scene in which the dominance of the medical considerations declines and the social aspects gradually assume equal or prevailing importance. It exemplifies a tendency on the part of the patient to re-establish himself in the more normal processes of living or, if handicapped, to adjust himself to his physical limitations.

TABLE 42. *Reason for Placement of Patients, by Diagnostic Classifications*

DIAGNOSTIC CLASSIFICATION	Total Patients	Reason for Placement			
		Medical	Social	Medical and Social	Not Reported
Total	322	152	86	83	1
Cardio-vascular diseases	129	63	33	33	..
Neurological and psychiatric conditions	55	27	17	11	..
Rheumatic diseases, disorders of metabolism and endocrine glands, vitamin deficiencies	42	25	6	10	1
Traumatic conditions, poisoning	20	10	3	7	..
Neoplasms	16	9	..	7	..
Diseases of the eye and ear	12	1	7	4	..
Diseases of the digestive system	9	5	3	1	..
Diseases of the uro-genital system	8	4	2	2	..
Blood, splenic, lymphatic diseases	5	1	1	3	..
Infectious diseases	4	3	1	..	..
Diseases of the respiratory system	3	2	1	..	..
Peritoneal and other abdominal conditions, hernia	2	..	1	1	..
Non-traumatic diseases of bones and organs of movement	2	..	2	..	..
Diseases of skin, cellular tissue	1	1	..	..	..
All other	5	1	1	3	..
Information inadequate to classify	9	..	8	1	..

Length of Stay

The majority of the patients had been in the respective nursing homes one year or less and only one-tenth for three years or longer. Although it is known that only seven of the 322 patients had been in another nursing or public home *immediately* prior to the present placement, it is possible that an additional number had been alternating between care in their own homes, in hospi-

tals and in nursing homes over a period of time. Therefore, the actual length of time spent by the patients in nursing homes generally might be greater than indicated. None of the findings in the study showed that the local public welfare departments reviewed their nursing home placements at well-defined intervals relative to the possibility of discharge. See Table 43.

TABLE 43. *Length of Stay of Patients in Present Homes*

LENGTH OF STAY	Patients	Per Cent	Cumulative Per Cent
Under 3 months	65	20.2	20.2
3–6 months	56	17.3	37.5
6 months–1 year	76	23.6	61.1
1–2 years	59	18.4	79.5
2–3 years	30	9.3	88.8
3–4 years	13	4.1	92.9
4–5 years	10	3.1	96.0
5 years and over	11	3.4	99.4
Unknown	2	0.6	100.0
Total	322	100.0	100.0

Cost of Care The cost of care in upstate New York ranged from $25 to over $80 per month with a concentration in the $40 to $65 range. On the other hand, two of the cases in New York City cost under $20 and the remainder $25 to $45 per month. These latter low rates were partially due to the fact that, at the time of the study, the New York City Department of Public Welfare regarded its placements as boarding home rather than nursing home placements. See Table 44.

TABLE 44. *Monthly Cost of Care of Public Assistance Patients*

MONTHLY COST	Total Patients	Upstate	New York City
Total	322	270	52
Under $20	2	..	2
$20 and under $25	..	..	..
$25 " " 30	13	5	8
30 " " 35	53	16	37
35 " " 40	16	14	2
40 " " 45	35	32	3
45 " " 50	14	14	..
50 " " 55	45	45	..
55 " " 60	50	50	..
60 " " 65	62	62	..
65 " " 70	17	17	..
70 " " 75	3	3	..
75 " " 80	9	9	..
$80 and over	2	2	..
Unknown	1	1	..

There was no conclusive evidence that the charges for care of bedridden cases exceeded those for ambulatory and semi-ambulatory cases with any consistency. This may have been due to local welfare officials bargaining with the nursing homes relative to rates and to encouraging the proprietors to admit public assistance cases at rates lower than might have been charged similar, non-dependent patients requiring identical service.

Nursing Homes Used

As previously noted, there were 802 public assistance cases receiving care in 148 different nursing homes in the 12 welfare districts. The 322 cases comprising the sample actually studied, and which are referred to in the foregoing pages, received care in 109 different nursing homes, all of which were studied.

Admission Policies Although the nursing homes generally had no written or printed admission policies, interviews with the respective proprietors indicated the types of cases generally accepted and those rejected for care. On the whole the homes were willing to admit convalescent, chronically ill, aged and infirm cases. With scattered exceptions the following types of cases were rejected—alcoholic, cancer, infectious disease (including tuberculosis), mental and post-surgical cases requiring extensive care as to dressings. The types of cases excluded show that the proprietors are generally unwilling to accept cases primarily of a mental hygiene nature (alcoholism, mental illness), cases that might be health menaces to the other patients (infectious diseases), cases whose medical natures might be offensive to the other patients (cancer) and cases requiring considerable nursing care (cancer, surgical dressing cases).

Population of the Homes At the time of the study the 109 nursing homes were caring for 1,362 patients, approximately half of whom were receiving public assistance. This large proportion lends credence to the speculation that the homes were largely of the type acceptable to the local public welfare officials. Actually, local departments do not generally use either the very low grade homes or the very high grade ones having high rates. They use the average nursing homes, the ones frequented by non-dependent patients in reasonable economic circumstances. Therefore, the findings on the homes studied do not depict the extremes of nursing homes but rather the usual ones used by a goodly portion of the general population.

Location All but 15 of the homes had urban or suburban locations—suggesting that the proprietors probably have found such locations more profitable, help more available and medical service more accessible. The rural locations occur in such predominantly rural counties as Essex, Fulton and Yates. Of every 10 homes four had been at their *present* address five years or longer, and five less than three years. Undoubtedly, some of the homes had moved from one location to another

thereby having short tenure. It is likewise plausible that the war-created overcrowding of general hospitals, the shortages of physicians and nurses, broken homes and congested housing conditions have encouraged proprietors to establish nursing homes to care for ill persons who might, under more normal conditions, receive care in their own homes or in general hospitals. This possibility is reinforced when one considers the reasons for placement in nursing homes, as previously presented in Table 42, page 112. See Table 45.

TABLE 45. *Length of Time of Homes at Present Location*

TIME AT PRESENT LOCATION	Number
Total	109
Less than 1 year	19
1 year and less than 2 years	13
2 years and less than 3 years	8
3 years and less than 4 years	11
4 years and less than 5 years	10
5 years and less than 10 years	26
10 years and over	20
Unknown	2

Capacity and Occupancy Thirty of the 109 homes could accommodate 20 or more patients each and 19 only five patients or less. These smaller units tend to be boarding homes calling themselves nursing homes. Unless their rates are high, it is improbable that they have the equipment, quality of staff or efficiency of operation which good nursing home care requires. They might be excellent in providing the ambulant ill with minor personal services, in addition to boarding home care, but their classification as nursing homes is questionable. See Table 46. The combined occupancy rate of the 16 nursing homes in New York City was 91.9 per cent, and of the 93 in upstate New York 83.5 per cent. The latter ranged from 39.5 per cent in Essex County to 90.8 per cent in New Rochelle.

TABLE 46. *Bed Capacities of Homes*

BED CAPACITY	Total Homes	Upstate	New York City
Total	109	93	16
Under 5	19	17	2
5–10	29	23	6
10–20	31	26	5
20–30	20	17 [1]	3
30 and over	10	10 [2]	..

[1] Binghamton City 1, Essex Co. 1, Monroe Co. 4, Nassau Co. 5, and Onondaga Co. 6.
[2] Monroe Co. 4, Nassau Co. 4, New Rochelle City 1 and Wyoming Co. 1.

Structure The inspectors visiting the homes considered *none* to be fireproof, only 22 fire retardent (six in New York City) and the other 87 "highly combustible" (10 in New York City). The most favorable report was in Monroe County where six of the eight homes were considered fire retardent. Although all but six homes had adequate water supplies for fire fighting, less than half had approved fire extinguishers, about three-quarters had alternate egresses from each floor and only one-quarter had fire escapes. Paid fire departments served 80 of these homes and volunteer departments 29. Ninety-eight of the 109 homes were considered as located "near" their respective fire departments.

Facilities The inspectors were also of the opinion that almost all the homes studied had comfortable beds, sufficient space between beds, adequate bed clothing, suitably lighted rooms and sufficient ventilation. However, those types of facilities closely related to the direct care of patients were not found in the majority of homes. Only 48 labelled drugs properly and locked them in closets. In others it was possible for patients to have rather free access to medicines prescribed for others and to narcotics often avidly sought by addicts. Half the homes (54) had adequate equipment for detailed nursing care, such as bedpans, urinals, dressing trays, reserve hypodermic needles and syringes. The lack of such equipment in others leads one to question how, lacking them, they are able to properly care for their patients. A negligible 18 homes had utility rooms for emptying bedpans, sterilizing dressings, syringes and other equipment, while most used bathrooms for this purpose.

Records Similarly, the reports of the inspectors cooperating in the study provided conclusive evidence that the homes were generally negligent in keeping any records, except registers listing identifying information on patients under care. This poor practice included failure to record instructions from physicians, to note the distribution of narcotics, and to enter nurses' notes of medication and treatment.[4] See Table 47.

TABLE 47. *Types of Records Maintained by Homes*

TYPE OF RECORD KEPT	Homes Maintaining Records [1]		
	Total	Upstate	New York City
Register of patients	61	57	4
Doctors' order book	31	27	4
Narcotic record	28	28	..
Nurses' notes of medication and treatment	45	41	4

[1] Out of a total of 109 homes, 93 in upstate New York and 16 in New York City.

[4] Good practice demands that no narcotics be available in a home except as ordered by a physician for a specified individual patient.

Staff One-third of the homes had registered nurses, either the proprietor herself or a member of the staff; one-half had either staff members or proprietors who are practical nurses; and the remainder had neither proprietors nor staff members trained as nurses, practical or otherwise. See Table 48.

TABLE 48. *Nursing Personnel of Homes*

TYPE OF NURSING PERSONNEL	Number of Homes
Total	109
Registered nurse	33
Graduate nurse	1
Licensed practical nurse	19
Other practical nurse	29
None	27

This general lack of adequately trained nursing personnel enforces the impression that many of these homes are more suited to provide custodial care requiring negligible nursing services than the active, high quality nursing care needed by ill persons. This lack undoubtedly affects the rapidity of convalescence, the arrest of debilitating medical conditions and the possibility of early discharge, thus prolonging the period of care and drain upon public funds.

Reaction of Patients One outstanding conclusion of the medical social workers and inspectors who worked on the study is that a patient apparently may be perfectly satisfied and content in a nursing home which is entirely inadequate from every standpoint relating to even minimum standards of care. This clearly indicates that the morale of individual patients, a vital factor in recovery, is closely related to the attitude of the proprietor and her staff, the accessibility of the nursing home to friends and relatives of the patient, and the similarity of the home to the previous environment of the patient.

PROBLEMS IN RELATION TO NURSING HOMES

While collecting data for the Nursing Home Study, the medical social workers and institutional inspectors of the State Department of Social Welfare recorded the problems mitigating against the proper operation and use of nursing homes. Some were common to several welfare districts, others were applicable to only one.

Several districts had a shortage of nursing homes or a lack of homes with adequate buildings, equipment and staff. Concurrently some nursing homes, often established in distressed and mortgaged property, were being sold because of financial delinquencies; some were closing because their proprietors sought augumented incomes in war industries; still others were converting from nursing homes to the more lucrative and less troublesome operation of boarding homes for war workers; and still others were closing because of their inability to comply with local fire and zoning regulations. At the same time a number of the homes in full operation were overcrowded, lacked personnel and were subject to rapid turnovers of staff.

Some districts reported nursing homes experiencing the problems similar to those of the local general hospitals and county home infirmaries. Overcrowded hospitals were limiting admissions and discharging patients before the end of the acute phase of illness, and care in nursing homes was consequently often sought as an alternative. Welfare districts having no county home infirmaries, those with crowded infirmaries and those with personnel shortages in their infirmaries were likewise turning to the nursing homes for care of their patients. More often than not there were not sufficient beds in satisfactory nursing homes to meet the demand. In at least one district this situation was further complicated by the unwillingness of the local nursing homes to admit Negro patients.

In addition to the problem of finding proper nursing home beds, some local departments had difficulty in administering and financing care in such homes. Nursing home rates were increasing and welfare officials were hard put to find satisfactory homes at rates they were able to pay, particularly since the cost of such care was technically not reimbursable by the State Department of Social Welfare and had to be totally financed by local tax funds.

CONCLUSIONS

The study shows that most welfare districts have no clear conception as to what a nursing home is, what is should offer and what criteria should be applied in selecting a home for placement of an ill person. Although many districts are aware that nursing home care is an integral part of medical care, as evidenced by their reference to medical judgment in making the placement, many fail to apply this conception following placement by requiring a high quality of medical-nursing care or by reviewing their placements at clearly defined intervals to determine progress or the possibility of discharge. The data also show that the homes were used only to a negligible extent, if at all, for convalescent service, one of the primary functions of nursing homes.

This lack of basic philosophy seems due to three major factors. *First*, four-fifths of the patients placed were 65 years old and over, were invariably recipients of Old Age Assistance and were suffering from physical incapacities requiring long-term care, such as heart, mental, rheumatic, metabolic, glandular, digestive and uro-genital conditions. Such cases often have poor prognoses, are discouraging, require patience, are not colorful and are frequently not amenable to rehabilitation. Consequently, they often fail to elicit the continuing interest and optimism of

welfare officials beyond a kindly and tolerant concern for the patient's happiness and a willingness to accede to his whims. *Secondly,* there had been no appreciable advisory or consultative leadership from the State in assisting the local departments of public welfare to properly make their nursing home service an integral part of their medical care programs, and to establish clearly defined standards relative thereto. Furthermore, the State had not formulated a published policy in regard to reimbursement for care in nursing homes. *Thirdly,* the demand for satisfactory nursing home beds, at a rate which local officials were willing to pay, exceeded the supply. Therefore, placements were often made in homes incapable of providing the quality of service which the medical condition, the morale of the patient and human dignity required.

The study gives support to the general impression that the nursing homes in the State are used almost to capacity, but are neither universally satisfactory nor unsatisfactory. Many have been in business a long time, have a clear idea of the types of cases they are able to handle, have adequate equipment and trained staffs and, despite wartime conditions, have tried to serve their patients. Others are extremely commercial in attitude, are housed in property ill suited and ill equipped to provide proper care, are too small for efficient operation and are of short tenure at their present locations. The wide range of quality and the transitory nature of many homes makes it unwise to put increasing reliance in nursing homes as a medical resource without simultaneously encouraging the establishment of alternate facilities of high quality to serve ill patients requiring active nursing rather than general hospital care. Furthermore, the homes are generally loathe to accept alcoholic cases or patients with mental conditions, yet, if such patients are not committable to State mental hospitals, some other provision for their care must be made.

Although the majority of patients in these homes were recipients of public assistance, there is no evidence that the local departments of public welfare have required, as a condition of placement, that the homes provide satisfactory medical and nursing service. This may have been due to several reasons—a lack of conception as to the quality of service required, an unwillingness to pay rates compatible with such service or unwillingness to make any demands which might encourage the proprietors to reject public assistance cases. Whatever the reason, or reasons, the situation could be alleviated by assisting local officials to understand the place of the nursing home in the medical care program, by making additional funds available for nursing home care and by encouraging the establishment of additional beds for such service.

SUBSEQUENT ACTION

As a result of collecting and analyzing the foregoing data, the New York State Department of Social Welfare issued Bulletin No. 105 on September 19, 1944. (See pages 117 to 121). The following statement of the Department[5] described the content of this directive and the results attributed to its issuance.

> "1. Issuance of a bulletin on nursing home care (No. 105) which accomplished certain desired objectives, such as:
>
> "a. Defining a nursing home for purposes of reimbursement, thus ending any misunderstanding on the part of local agencies as to the reimbursable categories. This was an important development since it assured state participation in meeting the cost of a type of care which, in a comparatively few years, had risen to proportions significant in volume and quality, as well as cost.
>
> "b. Making nursing home care a medical item reimbursable only when recommended in writing by the attending physician. Continued reimbursement in each case was made contingent upon treatment by the patient's physician during the entire period under care in a nursing home. This in itself is of some protection to the patient since it may be assumed that the attending physician, while in no way responsible for the inspection and certification of homes, will not countenance care which in his judgment is not adequate to meet the needs of the individual patient.
>
> "c. By omitting any price ceiling, either in the nursing home bulletin or in the 'Analytical Chart of Reimbursable Medical, Dental and Nursing Care,' the local agency was assured of state reimbursement on local prevailing rates for nursing home care. This improved standards because a higher quality of care could be demanded as higher fees were paid.
>
> "2. Setting up a plan of local certification of nursing homes with suggested minimum standards which has resulted in:
>
> "a. Establishment in Central Office (of the State Department of Social Welfare) of a complete file of nursing homes used by local commissioners of public welfare for recipients of assistance. The enormity of the problem is given emphasis during the process of using this file which shows where the homes are located, their per diem cost, and the number of available beds. On May 1, 1946, there were 447 nursing homes with 6,139 beds certified by commissioners of public welfare, or licensed under local laws or ordinances, for the care of recipients of assistance.[6]
>
> "b. Local commissioners of public welfare in accepting responsibility for certification have themselves become more acutely aware of all that is involved in nursing home care. In some instances, they have turned for assistance to local public health officials, to nurses or to practicing physicians and this has helped, directly or indirectly, to raise standards and to influence local thinking as to an ultimate and more satisfactory answer to the problem.
>
> "c. State and local welfare officials are together acquiring more and more knowledge and understanding of the place which the proper type of nursing home has in the community, of the increasing cost of providing such care, and of the need to evaluate their experiences in terms of future planning for the development of ade-

[5] Submitted by Commissioner Robert T. Lansdale, New York State Department of Social Welfare, to the New York State Health Preparedness Commission, May 17, 1946.

[6] The corresponding figure for July 1945 was 400 nursing homes with 5,110 beds.

quate, safe, and proper places for the convalescent, the chronically ill, and the person needing custodial care. Further scientific study is required in order to distinguish between the type of facility which is needed if convalescent care, for example, is to be given the recognition which it warrants in the total field of medical care planning, as contrasted with the widely different scope of services which may be indicated for the person requiring terminal or even custodial care. Furthermore, the interplay of medical and social elements is a significant factor which our study indicated to be of major importance."

BULLETIN NO. 105

STATE OF NEW YORK

DEPARTMENT OF SOCIAL WELFARE

ALBANY

REIMBURSABLE CARE IN A PRIVATE NURSING HOME

To: Commissioners of Public Welfare	Bulletin No. 105 September 19, 1944
Applicable in agencies administering: AB OAA HR (Including town welfare units)	Index Classifications: SOCIAL SERVICE: Investigation Grants Medical ACCOUNTING: Authorizations Rolls Orders Claims

INTRODUCTION

This bulletin defines a private nursing home for the purposes of reimbursement; outlines the scope of reimbursable nursing home care in such a home and the method of placement of patients therein, and describes the procedure for the certification and use of such a home by the local administrative agency, and indicates the procedure to be followed in claiming State reimbursement as public assistance for care in a private nursing home.

I. DEFINITION AND SCOPE

A. For the purposes of reimbursement in HR, OAA and AB a private nursing home is hereby defined as a home which is not publicly owned or operated and which offers board, room and bedside care for compensation to persons 16 years of age or over. Care in such a private nursing home shall be reimbursable when provided to a recipient of HR, OAA or AB for whom such care is recommended in writing by a licensed physician because of the nature of his illness, convalescence or infirmity and when provided in accordance with the regulations of the Department.

B. Reimbursable private nursing home care shall be construed to include, in addition to board, room and services normally provided in a boarding home, all nursing service, special diets, ordinary medical supplies, bedside care and attendance that may be required because of the nature of the patient's illness, convalescence or infirmity, and which reasonably may be expected from the proprietor or members of the private nursing home staff.

C. A private nursing home shall be equipped and staffed so that the proprietor or staff may provide the regimen prescribed by the patient's physician, that is, to give medication, bedside care, dressings, guidance and training in health habits, and supervision of diet and rest as required.

D. For the purposes of reimbursement care in a private nursing home as herein defined is not institutional care within the meaning of Section 157.1 of the Social Welfare Law.

E. Responsibility for standards of care in a private nursing home rests with the local administrative agency authorizing such care.

II. PLACEMENT

A. Placement in a private nursing home shall be made only on the basis of the diagnosis and written statement of a licensed physician that proper care can be provided in a private nursing home for the patient and that because of the nature of his illness, convalescence or infirmity, such care is necessary. If practicable, the physician's recommendation shall specify the particular care and services which the patient requires. The physician's statement shall be kept on file in the agency, either in the case record or the medical record. Fees paid for such examinations and reports shall be reimbursable.

B. Before any placement is made in a private nursing home, four points should be given careful consideration: (1) the patient's physical needs; (2) his personality; (3) his individual preference, and (4) the availability and comparative cost of other suitable care in the community.

C. Persons who in the opinion of a licensed physician require unusual or special types of nursing home care should be placed preferably in a private nursing home with a registered nurse as proprietor or member of the staff.

D. Persons in the following groups shall not be placed in a private nursing home:

1. Children under 16 years of age (See Rules of the Board, established pursuant to Sections 375, 376 and 380 of the Social Welfare Law).
2. Persons requiring care for mental illness under the supervision of the State Department of Mental Hygiene (See Bulletin No. 50, dated May 22, 1941). This does not refer to persons on parole from a State mental hospital.
3. Persons suffering from communicable disease in an infectious stage.
4. Persons in need of hospital care.
5. Persons in need of institutional care.

III. MEDICAL CARE

A. A patient receiving care in a private nursing home shall remain under continuing medical supervision. Continuing medical supervision of patients in a private nursing home shall be in accordance with the provisions of a State approved local medical care plan, except that, in public welfare districts not operating under such a plan, each private nursing home patient shall be visited by a physician as often as his condition may require, but not less often than once in three months. Reauthorization of care in a private nursing home shall be based upon the written recommendation of the attending physician or of the medical officer of a State approved local medical care plan.

B. Any change in recommendations for care of the patient should be promptly transmitted to the proprietor of the nursing home, either by the physician or by the local administrative agency.

C. Patients developing acute or severe symptoms requiring treatment in a hospital or other institution shall be promptly removed thereto, upon authorization of the local administrative agency, unless the attending physician states that in his opinion such removal is unsafe or unwise.

D. Medical, dental or nursing services which are required and can be provided only by a professional attendant not on the staff of the private nursing home or the local administra-

tive agency, including special nursing service in cases of acute or severe illness when the patient cannot be moved to a hospital, and any special and expensive drugs, medical supplies and prosthetic appliances prescribed by a physician, may be provided on an individual basis in accordance with the requirements of a State approved local medical care plan or of Bulletin No. 77d (Analytical Chart of Reimbursable Medical, Dental and Nursing Care).

E. Medical care records in a private nursing home shall conform with local minimum standards. (See Appendix B, Section D, for Recommended Minimum Standards.)

The local administrative agency shall transmit to the private nursing home at the time of placement of a patient, or as promptly thereafter as possible, a letter which indicates at least the following information:

1. Name, age and usual address of the patient.
2. Name and address of nearest relative.
3. Religion.
4. Case number and type or category of public assistance.
5. Method of payment (Direct or Indirect).
6. Name and address of physician who is responsible for continuing medical care and how he may be called.
7. Diagnosis and nature of patient's illness, convalescence or infirmity and physician's recommendations for regimen to be followed.
8. Person to be notified in case of emergnecy, critical illness, etc.

IV. CERTIFICATION

A. The local administrative agency planning to use a private nursing home situated within its own jurisdiction shall certify such a home annually. When a private nursing home within a town or city is used both by such town or city and by the county welfare department, agreement should be reached as to which welfare agency will visit and certify such home. A letter giving the date of certification of such private nursing home should be sent by the certifying agency to the other participating agencies and such home may be added to their approved lists. If the private nursing home lies outside the jurisdiction of the local administrative agency planning to use it, it is the responsibility of the public welfare official of the county in which it is located to visit and, in his discretion, certify such a home, if such visitation and certification has not already been made. Such certification may be accepted by the local administrative agency planning to use the home.

B. The local public welfare official, or his duly authorized agent, shall visit each private nursing home before certifying it and shall keep a record of such visit. In a public welfare district where private nursing homes are licensed by another public department, the public welfare official who plans to use a private nursing home may make his own visitation and certification or may accept in lieu of certification a written statement from the licensing agency that the nursing home has been duly licensed.

C. The public welfare official of the district in which the home is located shall issue a certificate to each approved private nursing home, which shall state the maximum bed capacity reserved for patients, and this number shall not be exceeded. A sample of such a certificate is shown in Appendix A, attached to this bulletin. Such certification of a private nursing home shall be renewed annually. The certificate becomes void at the end of each year and if the home changes its location or ownership. A public welfare official may revoke a certificate for cause.

D. Each certificate for a private nursing home shall indicate that reports are on file in the local administrative agency that the home has complied with existing ordinances and regulations of the local zoning, building, fire protection, sanitation and public health departments, as well as the provisions of Section 334 of the Public Health Law, and minimum standards determined by the local agency. (See Appendix B for Recommended Minimum Standards.) Such minimum standards for building and equipment, types of patients to be admitted, personnel and records provide the criteria by which the private nursing home shall be judged. The local administrative agency may choose to use a locally prepared form of "Application for Annual Certification of a Private Nursing Home." For the guidance of such agencies, in preparing such a form, a modified copy of the form now used in one county of the State is Appendix C attached to this bulletin.

E. An up-to-date list of certified or licensed private nursing homes shall be maintained in the local administrative agency. Such list including all additions and deletions shall be transmitted periodically to the area office either (a) as part of a State approved local medical care plan, or (b) if not operating under such a plan, as a triplicate list, two copies of which shall be sent by the area office to the central office of the Department.

V. REIMBURSEMENT

A. Payments for private nursing home care shall be reimbursable in accordance with the provisions of Bulletin 77d (Analytical Chart of Reimbursable Medical, Dental and Nursing Care) or a State-approved local medical care plan. The rate paid for care in a private nursing home should be based upon the needs of the patient and the facilities of the home. Payments for reimbursable private nursing home care shall be construed to include, in addition to board, room and services normally provided in a boarding home, all nursing service, special diets, ordinary medical supplies, bedside care patient's illness or infirmity, and which reasonably may be expected from the proprietor or members of the private nursing home staff.

B. Medical, dental, nursing and other professional services which are required and can be provided only by a professional attendant not on the staff of the private nursing home or the local administrative agency, including special nursing service in cases of acute or severe illness when the patient cannot be moved to a hospital, and any special and expensive drugs, medical supplies and prosthetic appliances prescribed by a physician may be authorized and shall be reimbursable on an individual basis in accordance with the requirements of a State approved local medical care plan or of Bulletin 77d (Analytical Chart of Reimbursable Medical, Dental and Nursing Care) which will shortly be released.

C. The method of payment and claim for reimbursement for care in a private nursing home shall be as follows:

1. For recipients of old age assistance and assistance to the blind, by the direct payment method, either by special check or by inclusion of the payment in the regular check. Indirect payment may be used only in accordance with the provisions of Bulletin 44.
2. For recipients of home relief:
   (a) In agencies operating under a cash relief plan *and* a State-approved local medical care plan, payment may be made either by the direct payment or indirect payment method at the option of the agency.
   (b) In agencies operating under a cash relief plan but *not* under a State-approved local medical care plan, payment shall be made by the indirect method, except where the agency has notified the area office and acknowledgment has been received that the direct payment method will be used.
   (c) In agencies not operating under a cash relief plan, payment will of course be made by the indirect method.

   NOTE: If the local administrative agency employs a physician or nurse on its staff, and designates him or her as its authorized agent to visit and certify private nursing homes, as provided in Section IV of the bulletin, the cost of such services are considered a reimbursable part of the salary. If no physician or nurse is on its staff, the local administrative agency may hire one, on a per diem

basis, to visit and certify private nursing homes, and such temporary salary would be reimbursable, subject to the provisions of Bulletin 5b.

VI. EFFECTIVE DATES

A. The definition of a private nursing home and the general policy relating to reimbursable private nursing home care covered in Section I of this bulletin—as well as Sections II, Placement, III, Medical Care, and V, Reimbursement, shall take effect immediately. However, in the case of recipients already placed in private nursing homes without the required physician's recommendation, a period of four months will be allowed to secure such recommendations.

B. The process of "Certification" covered by Section IV of this bulletin shall take effect as follows:

For a private nursing home placed in use after the other requirements of the bulletin take effect, the certification process herein outlined shall be followed if reimbursement is to be requested for the care of any person in such a home. Since it is recognized, however, that it will take time to visit and certify the private nursing homes already in use, an additional three months from October 1, 1944 will be allowed to complete the process and to certify such homes. After January 1, 1945 reimbursement will not be granted for the care of any person in a private nursing home unless such home has been certified as required in this bulletin.

APPENDIX A

(Sample—May be adapted to local use.)

CERTIFICATE

To Operate a PRIVATE NURSING HOME which Accepts Public Charges

This is to Certify, That I, ..., Town

Commissioner of Public Welfare of the City of ....., County

pursuant to the requirements established by the New York State Department of Social Welfare, have visited and examined the facilities and operation of

....., Name of Private Nursing Home

located at ....., and in Address

charge of ..... and I am satisfied that the private nursing home in question is adequately prepared to furnish the care and service to be provided by it for not to exceed a total of ..... patients. I have also investigated the question of adequate fire protection and the character of the applicant, and being satisfied of the same, do hereby issue a certificate to said

..... Name of Private Nursing Home

which certificate has become operative from the date of issue for the balance of the year ending .....

..... Issuing Agency

Signed by ..... Name and Title

Address .....

Date .....

APPENDIX B

Recommended Minimum Standards for a Private Nursing Home

A. BUILDING AND EQUIPMENT

1. The building shall be structurally sound, shall be maintained in a clean, sanitary condition free from hazards and shall have adequate heat, light and ventilation. All windows and doors shall be screened.

2. If over two stories in height, the building shall be provided with approved outside iron stairways with doorway exits leading thereto from each floor above the first on which patients are accommodated (as required by Section 334 of the Public Health Law).

3. Alternate means of egress shall be provided from each floor occupied by patients and all exits shall be marked with red lights.

4. All electrical wiring and all fire extinguishers shall meet the standards of the National Board of Fire Underwriters. An adequate number of suitable fire extinguishers shall be conveniently placed throughout the building.

5. The building shall be provided with a safe and adequate water supply and with sewage disposal facilities adequate for the maximum allowable occupancy.

6. All toilet rooms shall have outside ventilation, and separate toilet and lavatory facilities shall be provided for employees. Toilet facilities shall be provided as follows: at least one toilet and lavatory bowl on each occupied floor, one toilet and lavatory for each eight patients, one tub or shower for each sixteen patients.

7. A room shall be reserved for the isolation of seriously ill and terminal patients and those suffering from a communicable disease and requiring isolation.

8. All beds for patients shall be at least three feet apart.

9. An adequate supply of equipment essential for the care of bed patients shall be provided. Beds and bedding shall be maintained in a clean condition.

10. Suitable equipment and facilities for the storage, preparation and serving of food and the washing and disinfection of dishes and utensils shall be provided and maintained in repair and in a sanitary condition.

B. TYPES OF PATIENTS

Care shall be provided for sick, convalescent or infirm patients requiring complete or partial bedside care and ambulatory patients.

C. PERSONNEL

1. The proprietor shall be of reputable character regarding which two references shall be provided, one of whom shall be a licensed physician.

2. The staff shall be adequate in number and qualified by training or experience to render the care and other personal services necessary for the type of patients received.

3. The proprietor or another member of the staff shall be responsible for the planning, proper preparation and serving of an adequate, balanced, varied dietary adapted to the requirements of the individual patient.

4. The staff shall be instructed in the technique of fire fighting and in evacuating the building in an emergency.

D. RECORDS

1. Records of patients shall be regularly and continuously maintained and such records shall consist of a permanent register or file containing identifying data for each person cared for and individual patient records on which shall be entered the following information: name and address of patient, sex, color, age, marital status, occupation, place of birth, dates of admission and discharge, diagnoses, reason for discharge and if death, the cause of death, name of attending physician and name and address of nearest relative or friend.

2. Medical records shall provide space in which entries shall be made of clinical history, physicians' and nurses' notes regarding progress, medication and treatment.

3. A file of the letters received from the local administrative agency and/or physicians' statement of diagnosis and prescribed regimen shall be maintained.

4. Such records shall be kept available at all times for reference by representatives of the local administrative agency.

APPENDIX C

Department of Public Welfare

.....New York

.....Commissioner

(Sample—May be adapted to local use.)

APPLICATION FOR ANNUAL CERTIFICATE TO OPERATE A PRIVATE NURSING HOME

To the ..... Department of Public Welfare:

Application is hereby made for a certificate to operate a private nursing home, as follows:

1. Name of nursing home .....
2. Location ..... Street, ..., N. Y.
3. Owner of nursing home ..... owner of property .....
4. Name of person in charge ..... Telephone No. .....
5. Character of buildings housing patients (wood, brick) ..... number of stories high ..... number of rooms: for patients ....., for employees ....., for service....., total number of rooms (excluding bathrooms) .....
6. Other buildings .....

PERSONNEL

7. Chief executive ..... title .....
8. Training ....
9. Experience ....
10. Number of employees: male ....., female ....., Total .....

PATIENTS

11. From what sources are patients secured?..... .....
12. Admission requirements: age ....., sex ....., color .....
13. Type of cases accepted: Bed care: Complete (.....); Partial (.....); Ambulatory (.....).
14. Number of beds for patients: Male ....., female ....., total .....
15. Are windows in rooms of patients screened?.....

MEDICAL CARE AND SERVICE

16. Is a physician available to answer emergency calls? ....., if so, give name ....., address .....
17. Does a duly licensed physician make regular calls? .....
18. Who decides when physician shall be called?.....
19. Are physicians paid by nursing home, patient or others? .....

NURSING SERVICE

20. Number of registered professional (New York) nurses employed?.....
21. Number of licensed practical (New York) nurses employed? .....
22. Number of other paid attendants employed? .....
23. How many patients per nurse in daytime? ..... at night? .....
24. Who is in charge at night? .....
25. How often is bedding changed? ..... personal linen ....., patients bathed .....
26. Is medicine closet securely locked? ....., Who keeps key? .....
27. Bathrooms and toilets:

FLOOR	Population of Floor	Bath Rooms						Water Closets	Condition
		No.	Bath			Water Closets	Other Basins		
			Shower	Tubs	Basins				
Basement									
First									
Second									
Third									
Fourth									

28. Number of bedpans ....., urinals ....., commodes ....., where kept .....

UTILITIES

29. Water supply: municipal or district ....., other source ..... Is supply adequate at all times? .....
30. Sewage disposal: municipal ....., septic tank ....., cesspool .....
    Has sewerage system given any difficulty during the past year? ..... If so, what? .....
31. Heating system: steam ....., hot air ....., hot water ....., stoves ..... Fuel used: coal ....., oil ....., gas ..... Water heater ....., kind ....., is exhaust piped to outside? .....
32. Lighting: electricity ....., gas ....., oil ....., other (specify) .....
33. Laundry: location ....., equipment ..... Safeguards for machinery? .....

34. Kitchen: location ....., size—length ....., width ..... height ..... Range: gas ....., electric ....., coal ....., oil ..... Number of windows ....., are windows screened? ..... number of doors .....

35. Food storage .....

.....

36. Refrigerator: location ....., type ....., size .....

37. Garbage: are covered containers used? ....., where are containers kept? ....., collection made by whom? ....., frequency of collection? .....

38. Do you agree to notify the department of public welfare prior to making any alterations in the building, or providing accommodations for additional patients? .....

39. Have you secured all necessary permits, licenses or approvals as may be required by local ordinances for zoning, building, or fire inspection? (Attach copies of such licenses, permits or approvals to this application)

.....

.....

40. Do you understand the statements, the questions and answers made thereto in this application and do you agree, if granted a certificate, to conform to commitments herein made? .....

41. Do you understand that such certificate, if granted, may be suspended at any time by the ..... commissioner of public welfare for violation of the conditions of such certificate, or otherwise when deemed by said commissioner necessary for the protection of the public health and welfare and that such certificate may be revoked by said commissioner after hearing on due notice? .....

.....
(Signature of applicant)

.....
(Title or status of applicant)

STATE OF NEW YORK)
COUNTY OF .....) ss:

....., being duly sworn, says that he/she has read and signed the foregoing application and that the statements therein made are true and correct.

.....
(Signature of applicant)

Sworn before me this ..... day of ..... 194...

.....

Notary Public ..... County

FOR OFFICE RECORD ONLY

Visits made by: .....

Dates of visits: ..... 194..., ... 194..., ... 194..., ... 194...

Approved for certificate by: .....

Title ....., 194...

Certificate issued by: .....

Title ....., 194...

STATEMENT OF CHARACTER WITNESS
(A Licensed Physician)

.....

.....

.....M. D.
(Signature)

.....
(Address)

STATEMENT OF CHARACTER WITNESS

.....

.....

.....

.....
(Signature)

.....
(Title)

.....
(Address)

REGULATION OF NURSING HOMES IN NEW YORK STATE*

The mushroom growth of any type of institution is apt to elicit public attention; and when the institution is used for the care of the sick, the aged or the handicapped, the quality of care provided inevitably commands public concern. This has been true of nursing homes. Their emergence in volume, reputedly stimulated by the scarcity of nurses, of general hospital beds, of beds in public homes, and by the frequent unwillingness or inability of the latter to admit paying patients, has been rapid. From July 1945 to May 1946, a period of only 10 months, the number of nursing homes certified for use by local departments of public welfare in New York State[1] rose from 400 homes with 5,110 beds to 447 homes with 6,139 beds, an increase of 12 per cent in the number of homes and 20 per cent in the number of beds; and these figures do not include additional homes which, although not used by local welfare units, are patronized by the general non-indigent public.

When question arises regarding the quality of a number of similar institutions, the public tends to look for a remedy in some form of official regulation or restriction. In the case of institutions the most obvious method of regulation, and the one considered easiest to establish, is licensure. This trend has been evidenced in the State by a number of local communities which have adopted official regulatory action relative to nursing homes.

As of November 1945 specific ordinances or regulations licensing nursing homes were in force in the cities of Mt. Vernon, New Rochelle, New York, Syracuse, and Yonkers and the County of Nassau. Some form of legal control, not aimed specifically at nursing homes, was in force in Buffalo, Rochester, White Plains and the Consolidated Health District of Saranac Lake and Harrietstown.

LEGAL CONTROLS NOW IN FORCE, EXCLUSIVE OF LICENSURE

Buffalo. The Lodging House Ordinance of the City of Buffalo requires that the operation and maintenance of a convalescent home (or nursing home) be subject to the same requirements exacted of rooming houses.[2] Individuals requesting a permit must file a floor plan for approval with the City Division of Buildings and the City Fire Department, in addition to the City Department of Health. Before a permit is issued for the establishment of a convalescent home, a hearing is held before the Commissioner of Health at which owners of property within 800 feet of the proposed home may voice approval or disapproval. If approved by the Commissioner, a permit marked for rooming house and convalescent home purposes is issued. Permits, which may be revoked for cause, are for one year ending each February first. Fees range from $5 per annum for homes with a capacity of two, to $20 for capacities of 25 and over.

Rochester. Since May 1, 1945, the City of Rochester has required the registration of "all private proprietary hospitals, sanatoria, nursing homes, convalescent homes . . . and homes for the aged or chronic patients" receiving individuals for "medical attention and/or nursing care and/or custodial supervision."[3] Certificates of registration need not be renewed and carry no expiration date. The Commissioner of Safety, before passing upon the application, can require information necessary for public safety and health. He can formulate and enforce rules and regulations for this purpose, must distribute notice of them to the proprietors and has the right of inspection when and where he considers it appropriate. No registration fee is required. Failure to register or to comply with regulations is cause for revoking the certificate and is punishable by a fine up to $150 or by imprisonment up to 150 days or by both, or by a fine of $5 to $500.

In brief, this ordinance makes registration mandatory for the home, inspection optional with the Commissioner of Safety and non-conformance to regulations punishable.

White Plains. White Plains, like Buffalo, includes nursing and convalescent homes in its city ordinance regulating and licensing hotels, rooming houses and furnished rooms.[4] However, the ordinance provides that the Commissioner of Public Safety shall require from each nursing home a supplementary application which is referred to the City Commissioner of Public Welfare for action. Homes with less than three accommodations are not subject to regulation. Requirements cover light, ventilation, sanitation, cleanliness, fire hazards, space per occupant, food handling and method of registration of guests. Licenses for operation as a congregate dwelling are for the calendar year, can be revoked for cause and range from $5 per annum for homes with three accommodations to $25 for homes with 17 or more.

Actually, this ordinance is designed to control the various aspects of congregate living and, although giving special consideration to nursing and convalescent homes, is not specific for them.

Consolidated Health District of Saranac Lake and Harrietstown. This Health District, located in both Essex and Franklin Counties, adopted regulations on November 29, 1933, addressed to the standardization of private sanatoria, with special emphasis upon

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* This material was previously published in mimeographed form by the Commission in September, 1946.

[1] Certification is the process whereby local departments of public welfare, on the basis of their respective locally established standards, approve nursing homes for the placement of their respective clients, as a requisite for State reimbursement. Such homes admit paying patients as well as the indigent.

[2] *Ordinances of the City of Buffalo*, Chapter XXV.

[3] *Rochester Municipal Code*, Vol. II, Chapter 66.1.

[4] *Official Proceedings of the Common Council of the City of White Plains*, Vol. 29, p. 573 (December 20, 1944).

those accepting cases of tuberculosis. Licenses are issued for one year, expiring each July first.

LEGAL REQUIREMENTS FOR LICENSURE

In the five cities and one county having licensure, the local *ordinance* enunciates the general legal requirements, while the *regulations* formulated by the unit of government administering licensure list requirements in detail. The specifications discussed in the following pages are summarized in Figures 5 and 6 on pages 129 to 131.[5]

Dates of Establishment of Licensure — Although Yonkers has licensed nursing homes since 1922 and New York City since 1929, the licensing of nursing homes generally has been a growth of the recent war years, the period of crowded general hospitals, the years of shortages of physicians and nurses, the time of increasing numbers of nursing homes. There are indications that the initiation of licensure was caused by official consciousness of the growing number of nursing homes, inquiries from citizens as to which nursing homes provide adequate service and public complaints on the quality of care in some homes.

Licensing Agency, Period and Fees — The local department of health is the licensing and inspecting agency, except in New York City where the Department of Hospitals is responsible. In all cases the licensure period is one year, usually the calendar year; licenses are not transferable and can be revoked for cause. The fee required is $10 in Nassau County and $25 in New Rochelle, Syracuse and Yonkers. No fee is exacted in New York City or in Nassau County.

Definition — Although the definitions describing the facility covered by licensure vary, the general import is that it is a proprietary institution accepting convalescent, chronically ill or infirm patients not in need of hospitalization for medical, nursing and/or custodial care. In Mt. Vernon, New Rochelle and New York City, operations in multiple dwellings are ineligible for licensure. The definition applicable in New York City, which is the most detailed, also defines the types of operations excluded from licensure, i. e., institutions incorporated by special acts of the Legislature, those under the State Department of Social Welfare and those licensed under the State Mental Hygiene Law.

The broadest definition, and conceivably the most difficult to administer, exists in Yonkers where licensure covers "a private hospital or other place where human beings are received for medical, surgical or obstetrical treatment." This definition is subject to wide interpretation.

Conformance to Other Legal Requirements — The ordinances state that, as a condition of licensure, and frequently as a part of the application procedure, the nursing homes must comply with local building and fire requirements, sanitary codes and zoning regulations (Nassau County, New Rochelle, Syracuse). Mt. Vernon, New York City and Yonkers also require prior approval by their departments of water supply.

REGULATIONS GOVERNING LICENSURE

The following discussion of requirements, based upon local regulations, is not intended to evaluate the extent or quality of the respective local licensing methods.

Publication of Regulations — In order that the applicant might be advised of the requirements which he will be expected to meet, the cities of Mt. Vernon, New Rochelle and New York and the County of Nassau have printed their regulations for distribution, Syracuse, although it publishes the ordinance, does not have available copies of its regulations, if any. Consequently, the proprietor must take the word of the inspecting personnel relative to such requirements as the storage of drugs, space between beds, ratio of toilets and lavatories to patients, etc. Yonkers has published neither its ordinance nor regulations for distribution. Hence, the proprietors in this city are not advised in due form of the specifications they are expected to meet.

Applications — The ordinances or regulations of all the localities require that the prospective proprietor of a nursing home file an application for a license prior to the establishment of a home. Thus the communities are able to prevent the opening of homes not likely to meet requirements.

Coordination of Requirements — In these six communities the licensing department functions as a coordinating unit. In each it receives properly completed statements from its local building, zoning, fire, water and sanitation department authorities attesting that the nursing home requesting a license either does or does not comply with the ordinances and regulations which they are respectively charged with enforcing. When such requirements have been met, the licensing agency inspects the nursing home to ascertain its compliance with the additional specifications contained in the regulations and issues a license if these conditions are fulfilled.

Structure and Facilities — In general, the regulations cover the type of structure, fire protection, sanitation, water supply, spacing of beds, ventilation, heating, toilet and lavatory facilities and food handling. Although consideration is probably given to the storage of drugs

[5] Grateful acknowledgment is made to the State Department of Social Welfare for its suggestions relative to the format of these charts.

and narcotics in the nursing homes of Yonkers, its ordinance makes no mention thereof. Mt. Vernon and New York City, possibly anticipating the establishment of more elaborate operations, require that facilities having clinical laboratories, x-ray services, pharmacies or drug rooms must have special permits therefor.

Type Patients Admitted — Only Syracuse requires that admission to a nursing home be based on the authorization of a physician. However, all specifically indicate the types of patients which may be admitted for care: (1) patients not in need of active hospital treatment, (2) surgical cases requiring minor post-operative care and (3) the chronically ill.[6] Mental cases are excluded. In New Rochelle tuberculosis cases are specifically excluded; in Yonkers drug addiction and communicable disease cases; and in Syracuse prenatal and maternity, epileptic, drug addict, alcoholic and communicable disease cases.[7] There is a tendency to require the removal of patients who, after admission, become acutely ill and need hospitalization.

Medical and Nursing Service — None of the communities seems to require a continuity of medical service for the patient, and only in New York City must each home have a responsible medical board. However, except in Mt. Vernon and Yonkers, each home must have at least one registered nurse who may be either the proprietor or a member of the staff.[8] It is probably assumed that the nurse would be responsible for seeing that patients receive medical care, as needed.

Records and Reports — All the localities require nursing homes to keep records on individual patients, ranging from summaries of identifying information to records covering chronological entries of clinical history and treatment. The submission of periodic reports to the governmental licensing unit, required by all but New Rochelle and Yonkers, range from reports showing only the census of the home to others showing the movement of population, diagnostic classifications of patients and detailed data on accidents.

DISCUSSION

Conclusions reached on the basis of a review of only the ordinances and regulations admittedly fail to give consideration to the human, subjective aspects of licensure, i. e., the quality of the inspections and the positive results attainable when experienced, trained, conscientious inspectors teach and advise nursing home proprietors. However, the content of the regulations themselves, re-enforced by opinions expressed by qualified local individuals, point to the conclusion that licensure in these communities is generally focused on the physical and sanitary aspects—building construction, fire protection, sanition—and is less concerned about the continuity and quality of medical, nursing and dietary service afforded the patient, his morale and his potentiality for convalescence and rehabilitation. Moreover, the care provided too often tends to be custodial.

Conferences of the Commission staff with public health, medical and social welfare personnel in these communities having licensure lead to several general conclusions. Though each is applicable to most of the communities, sometimes all, there are exceptions.

The existence of licensure tends to serve notice on nursing home proprietors that the public is watchful; it aids in raising standards of care, but often not greatly; it restrains the establishment of potentially low grade operations; and it is effective in closing some homes, though prosecution for infractions is generally reported as difficult.

Some basic administrative problems exist. (1) Since the jurisdiction of a city licensing nursing homes extends only to its boundaries, it cannot continue to regulate homes it closes for violations when they reopen just across the city line in contiguous county territory not covered by licensure. Under such circumstances licensure is a technical regulatory method which, realistically, does not have the full corrective influence intended. (2) Licensing authorities report difficulty in distinguishing between nursing homes serving semi-ambulant patients, which are subject to licensure, and self-classified boarding homes caring for the same type of patient, which are subject to rooming house regulations but not licensure. Consequently, local administrators, seeing the similarity of these two types of facilities, and mindful of their responsibility toward the sick, cannot decide where "nursing homes end and boarding homes for the aged, chronically ill begin." (3) Overlapping jurisdictions within a county which has chosen an optional form of county government poses still another problem. For example, by State law the authority of the Fire Marshal of Nassau County is superseded by that of the city, village and town fire marshals in requiring fireproof or fire resistant construction.[9] The latter must pass on the fire safety and structural requirements of licensure of nursing homes in their respective localities, using varying local standards as their criteria. Thus, although licensure is on the county level, the County Department of Health being the official licensing agency, inspectional jurisdiction is divided. The fire and building aspects are primarily the province of local officials and the sanitation and medical aspects the responsibility of county officials. This is not only administratively cumbersome but also creates a lack of uniformity in fire safety and

[6] NOTE: This is an example of the widespread tendency to use the term "chronically ill" as meaning "not needing active hospital care."

[7] Except that, with the approval of the Commissioner of Health of Syracuse, certain nursing homes may be designated to care only for selected cases of tuberculosis.

[8] Conformance to this regulation has been most difficult in wartime because of the nurse shortage.

[9] "Optional Forms of County Government," *County Law of New York State*, Sec. 393, 394.

construction standards throughout the county. (4) Since licensure in cities usually includes requirements relative to construction, zoning, fire safety, water supply and sanitation, the local licensing agency must coordinate the inspections of nursing homes made by personnel of the various departments responsible for these respective aspects. Although investigation by such properly qualified personnel is most desirable, the coordination of the findings are time-consuming and, as the various inspectors generally visit a nursing home separately, each proprietor must give time to several visitors, and the inspectors do not have ample opportunity to exchange findings and opinions.

The gap between the actual effectiveness of licensure and the hoped for results is due just as much to the very nature of nursing homes and of war-wrought conditions as to the quality of enforcement and problems of administration. Since nursing homes are so frequently opened in family size, converted dwellings, often in distressed property, they are necessarily small operations incapable of spreading their overhead costs widely. Therefore, if they are to be properly equipped and operated, they must either charge high rates or economize greatly in order to permit lower fees. The houses frequently are not fireproof, yet there is no evident tendency for several proprietors to band together, jointly acquire a suitable capital structure and, in partnership, operate a sizable facility of good quality with the overhead spread over a larger number of patients.

The shortage of personnel and the demand for beds at low rates are also factors. The lack of adequate staffs in many licensing agencies during wartime has precluded competent, timely inspections and the provision of consultant services to the proprietors. Shortages of nurses, maintenance manpower and construction materials have made it difficult, frequently impossible, to enforce regulations relative to qualifications of personnel, their ratio to patient loads, physical structure and equipment. The expanding demand for nursing home beds has discouraged enforcement agencies from closing many acknowledged substandard homes when alternate places of care for patients were not available. Unfortunately, some local departments of public welfare patronize low-rate, poor quality nursing homes, which the local licensing agency hesitates to close for lack of alternate facilities at similar fees. Conversely, other local departments of public welfare refuse to patronize nursing homes which they regard as of poor quality, even though licensed.

These are some of the better recognized problems inherent in local licensure of nursing homes. They are presented not as criticisms of licensure as a technique of control, but in an effort to focus attention on the difficulties involved in making this method operable, effective and administratively efficient.

CERTIFICATION OF NURSING HOMES BY LOCAL DEPARTMENTS OF WELFARE

No uniform, official, statewide regulation of nursing homes exists today in New York State. As previously noted, some local communities exercise licensure powers and other legal regulations short of licensure.

In addition, local departments of public welfare certify nursing homes for purposes of State reimbursement, a requirement growing out of the study, made by the State Department of Social Welfare in 1943, of selected nursing homes and their public assistance patients.[10] The conditions requisite to reimbursement were set forth in the Department's Bulletin No. 105,[11] issued September 19, 1944, which (1) officially defined a nursing home for purposes of reimbursement; (2) established nursing home care as a medical item, reimbursable only when recommended by the attending physician; and (3) removed ceilings from rates reimbursable by the State.

Such reimbursement is contingent upon the local department of welfare's certifying the nursing homes used; and, although the State Department suggests minimum standards for such certification, these are not mandatory. Therefore, each local commissioner of welfare is free to apply those standards he sees fit. Moreover, many of these officials and their staffs necessarily lack the experience and training needed to judge the quality of nursing homes. Consequently, there is no uniformity of criteria applied in certification among the various localities and no consistent, statewide minimum standards of care. The quality of care probably varies with local social-mindedness, competency, and financial means.

There is little doubt that State financial participation and the liftings of ceilings from reimbursable rates has improved the quality of nursing home care provided for the medically indigent and, as a by-product, that given the paying patients patronizing the same homes. However, it is equally true that were the criteria mandatory rather than suggested, and were they supplemented with State leadership in establishing local inspection (or certification) services of high quality, better results would be possible. However, even under such circumstances, certification would not result in complete coverage of the nursing homes in the State. It would still apply only to the homes which admitted medically indigent patients.

[10] Reported in "A Study of Nursing Homes in New York State, 1943." (Reprinted supra, pages 107 to 121.)

[11] Included supra as pages 117 to 121.

SOME SUGGESTED RECOMMENDATIONS

Regulation of standards and facilities of nursing homes is needed. It should apply to all nursing homes, and should be on the State level to obviate problems of jurisdictional boundaries between counties and within counties, and to insure a high quality of inspection service to communities financially or otherwise unable to provide such service.

On the basis of the foregoing presentation the following principles are suggested in considering, formulating, establishing and administering statewide official regulation of nursing homes.

1. Regulation should apply to all nursing homes, regardless of whether under proprietary, voluntary or public auspices.
2. When their facilities and staffs permit, local official agencies (county or city) should have the option of administering the regulatory process within their respective jurisdictions under State formulated minimum standards.
3. Inspections relative to the sanitation, fire safety and structural standards should be made by the State or local official departments technically qualified and legally responsible for these aspects of the public safety. Preferably, such departments should assign proper personnel for this purpose to the enforcement agency.
4. Inspections of nursing homes should be made by a "team" of specialists, each member thereof to be qualified by training and experience to pass judgment on those aspects of regulation coming within his respective field of competency. The "team" should visit a nursing home as a group, its members should consult each other to insure consistency of conclusions and should submit a composite report.
5. Specific minimum standards should be formulated, published and distributed and should be applicable to each nursing home in the State. Such standards should include those relative to admissions and quality and continuity of medical and nursing care, as well as those relative to physical structure, fire safety, sanitation, accommodations, equipment and facilities.
6. Any method of regulation established should be legally capable of deterring the opening of any new nursing home which, on the basis of data and and structural plans submitted by the potential operator (individual, association, church group, fraternal order or governmental unit), is adjudged incapable of meeting the established minimum standards of operation.
7. The State administrative agency should be just as responsible for teaching and assisting the nursing homes as for censuring them, i. e., in addition to formulating and enforcing standards it should offer constructive consultative and advisory service, upon request, to those nursing homes wishing to improve their operations.
8. The administrative responsibility should include the obligation to maintain records to insure a continuing basis of study of the nursing home situation and the regulatory process so that both might constantly be improved, on the basis of fact.
9. The nature of any regulatory process established should take cognizance of the manpower situation as it relates to the administrative staff, i. e., it should ensure completed coverage of nursing homes regarding details considered of fundamental importance and, instead of "spreading thin" on other aspects of regulation, should concentrate its efforts on those aspects most beneficial to the public interest.
10. Enforcement of regulations must be so executed as to preclude the closing of nursing homes when alternate facilities do not exist for placement of the patients who would thus be displaced.

REGISTRATION

In order to secure the maximum attainable benefit in setting and raising standards, allowing opportunity for teaching administrators of nursing homes and permitting public authorities to obtain current information, a system of registration, combined with the power to formulate and enforce regulations, would seem a suitable method for improving the quality of nursing homes in New York State, particularly under currently prevailing circumstances. This would allow for the application of the preceding principles, would avoid the rigidity inherent in the traditional licensure system and would meet the objection that licensure would merely close down facilities which, though far from ideal, are better than nothing at all.

Moreover, if licensure were the method of regulation chosen, the licensing agency would be legally obligated to inspect *each* nursing home probably annually or, less preferably, biennially. If qualified personnel were not readily available, the administering agency might have to "spread thin" its inspection service to reach each home, thus attenuating the quality of inspection of all homes. Registration would obviate such a legal responsibility.

The following are envisioned as the major characteristics of registration:

1. A certificate of registration would be required to be posted in every nursing home in the State as a condition of operation.
2. Certificates of registration would carry no expiration date and would be valid for an indefinite period, subject to revocation for cause.
3. On or before the effective date of registration, each nursing home in the State would be required to file with legally designated officials a completed official application for a certificate of registration, the administrative agency automatically approving all such applications.
4. Upon filing the completed application form, each such registrant (nursing home) would receive a copy of the minimum standards for operation of nursing homes, fulfillment of which would be requisite to continued operation.
5. Subsequently, the administrative State agency would inspect those nursing homes in which inspection seemed most needed and, if necessary, could effect improvement through (a) offering advice and consultation; (b) placing the registrant on probation; (c) fine the offender, subject to appeal; or (d) revoke the certificate of registration, subject to appeal.
   (It should be noted that the administrative agency would not be obligated to inspect each nursing home at specified intervals, but could, if limitations of personnel require, deploy its manpower to inspect and advise those homes which, in the public interest, seemed to demand immediate attention. Others could be brought under purview as the situation demanded and/or the availability of qualified staff allowed.)
6. Each individual or group contemplating the establishment of a nursing home would be required, as

a condition of opening, to file a completed, official application for a certificate of registration, accompanied by specified data, including structural plans. Approval of such applications by the enforcement agency would be based on a determination of the applicant's ability to meet the established minimum standards.

7. Plans for new construction or remodeling, the increasing of the bed capacity and the amendment of admission policies of any nursing home should be subject to approval of the enforcement agency.

The use of the registration method as a means of regulation could effectively fulfill the principles previously suggested. Although its staff probably would be unable to visit all nursing homes at the outset, the administrative agency gradually and systematically could achieve complete coverage, while at the same time providing consultative and advisory service. It should dedicate itself to quality, not merely quantity, performance.

FIGURE 5. *Requirements of Cities and Counties Licensing Nursing Homes, New York State, 1946*

CITY OR COUNTY	Ordinance and/or Regulations	Definition of Facility	Department Responsible for Inspection and Licensure	Effective Date	Period Covered by License	Fee per Period	License Revoked for Cause	Regulations Published and/or Available for Distribution	Application for License Required Prior to Establishment of Home	Conformance to Other Legal Requirements				
										Building	Zoning	Fire	Water	Sanitary Code
Mt. Vernon City	City Ordinance, Sec. 167, adopted Nov. 12, 1942. Sanitary Code, Art. XV-A, adopted Feb. 27, 1943, entitled: Regulations Governing the Establishment and Maintenance of Private Proprietary Nursing Homes, Convalescent Homes and Homes for the Aged or for Chronic Patients Within the City of Mt. Vernon.	"All proprietary hospitals, sanatoria, nursing homes, convalescent homes, homes for the aged or for chronic patients or other proprietary institutions wherein human beings are receiving or may receive medical attention and/or nursing care and/or custodial supervision." *Note #1:* The name of such an institution *must* include the words "Nursing Home," "Convalescent Home," "Home for Aged," "Home for Chronic Patients" or some similar descriptive phrase. The words "Hospital" or "Sanatorium" *must not* be used. *Note #2:* No license shall be issued for operations in a dwelling occupied as the residence or home of two or more families living independent of each other, including a hotel.	Dept. of Health	2/27/43	Year ending Apr. 30	None	x	Yes	Yes	x		x	x	x
Nassau County	County Public Health Ordinance, Art. VI, adopted Sept. 9, 1941, entitled: Homes for the Care of the Sick and Infirm.	"Homes for the care of the sick and infirm for compensation where three or more inmates thereof are or may be accommodated, including nursing homes, homes for the care of sick, convalescent or infirm patients or inmates."	Dept. of Health	10/1/41	Calendar year	$10	x	Yes	Yes	x	x	x		x
New Rochelle City	City Sanitary Code, Art. VI, approved by City Council Nov. 8, 1943, entitled: Licensing and Control of Homes for the Care of the Sick or Infirm.	"Any home offering or giving care for compensation to the aged, to any person convalescing from any disease or ailment or to any person suffering from or afflicted with any chronic disease or ailment." *Note:* Home shall not be used as a dwelling place for any family or person other than inmates and those immediately responsible for the operation of the home.	Dept. of Health	3/5/41	Calendar year	$25	x	Yes	Yes	x	x	x		x
New York City	New York City Charter, Sec. 583:2, adopted Nov. 3, 1936. Effective Jan. 1, 1938. Regulations Governing the Establishment and Maintenance of Private Proprietary Nursing Homes, Convalescent Homes and Homes for the Aged or for Chronic Patients, 1929 (Revised in 1936 and 1942).	Within the discretion of the Commissioner of Hospitals. "All private proprietary hospitals, sanatoria, nursing homes, convalescent homes, homes for the aged or for chronic patients, or other private proprietary institutions wherein human beings are receiving, or may receive medical attention and/or nursing care and/or custodial supervision, unless such institutions are incorporated by special act of the legislature, or are under the state department of social welfare or are duly licensed under the provisions of the mental hygiene law." *Note:* No license issued to a facility operating in a multiple dwelling, including hotels. Regulations not applied to facilities with four or less patients.	Dept. of Hospitals	1929	One year from date of issuance	None	x	Yes	Yes	x		x	x	x

CITY OR COUNTY	Ordinance and/or Regulations	Definition of Facility	Department Responsible for Inspection and Licensure	Effective Date	Period Covered by License	Fee per Period	License Revoked for Cause	Regulations Published and/or Available for Distribution	Application for License Required Prior to Establishment of Home	Conformance to Other Legal Requirements				
										Building	Zoning	Fire	Water	Sanitary Code
Syracuse City	City Ordinance Providing for the Licensing and Control of Nursing and Convalescent Homes, approved 1943.	"Homes for the care of sick or infirm for compensation where three or more inmates thereof are or may be accommodated, including nursing homes, homes for the care of the sick, convalescent or infirm patients or inmates."	Dept. of Health	9/1/43	Calendar year	$25	x	Ordinance but not specific regulations available	Yes	x	x	x	x	x
Yonkers City	General City Ordinance No. 19, adopted July 5, 1922, entitled: Ordinance Relating to Public or Private Hospitals or Institutions.	"A private hospital or other place where human beings are received for medical, surgical or obstetrical treatment."	Dept of Health	7/11/22	One year from date of issuance	$25	x	No	Yes	x		x		x

New York State Health Preparedness Commission.

FIGURE 6. *Licensing Regulations of Cities and Counties Licensing Nursing Homes, New York State, 1946* [1]

CITY OR COUNTY	Plant										Compliance with Sanitary Code	Services Requiring Special Permits	Authorization of Physician Required for Admission	Admission of Patients		Medical Board Required	Nursing Staff Required			Records Required on Individual Patients	Reports Required
	Building	Fire Protection	Sanitation	Water Supply	Heating	Bed Spacing	Ventilation	Lavatory and Toilet Ratio to Patients	Food Handling	Drug Storage				Admitted	Excluded		Registered Nurse	Practical Nurse *at Least*	Not Specified		
Mt. Vernon City	x	x	x	x		x	x	x	x	x	x	Clinical laboratory X-ray department Pharmacy or drug room		Patients not in need of active hospital treatment Surgical patients requiring minor post-operative care Chronic medical patients	Mental disease			x		x	x
Nassau County	x	x	x	x	x	x	x	x	x	x	x			Patients not in need of active hospital treatment	Mental disease		x			x	x
New Rochelle City	x	x	x	x	x	x	x	x	x	x	x			Patients not in need of active hospital treatment	Mental disease Tuberculosis		x			x	
New York City	x	x	x	x	x	x	x	x	x	x	x	Clinical laboratory X-ray department Pharmacy or drug room		Patients not in need of active hospital treatment Surgical patients requiring minor post-operative care Chronic medical patients	Mental disease	x	x			x	x
Syracuse City	x	x	x	x	x	x		x	x	x	x		x	Patients not in need of active hospital treatment Surgical patients requiring minor post-operative care Chronic medical patients	Mental disease Patients requiring prenatal or maternity care Epilepsy Drug addictio Alcoholics Communicable disease [2]		x [3]			x	x
Yonkers City	x	x	x			x	x	x			x			Patients not in need of active hospital treatment Surgical patients requiring minor post-operative care Chronic medical patients	Drug addiction Mental disease Communicable disease			x		x	

[1] Data based on local ordinances and regulations.
[2] With approval of the Commissioner of Health, certain nursing homes may be designated to care *only* for selected cases of tuberculosis.
[3] Or a nurse possessing such other qualifications as the Commissioner of Health may prescribe.

New York State Health Preparedness Commission.

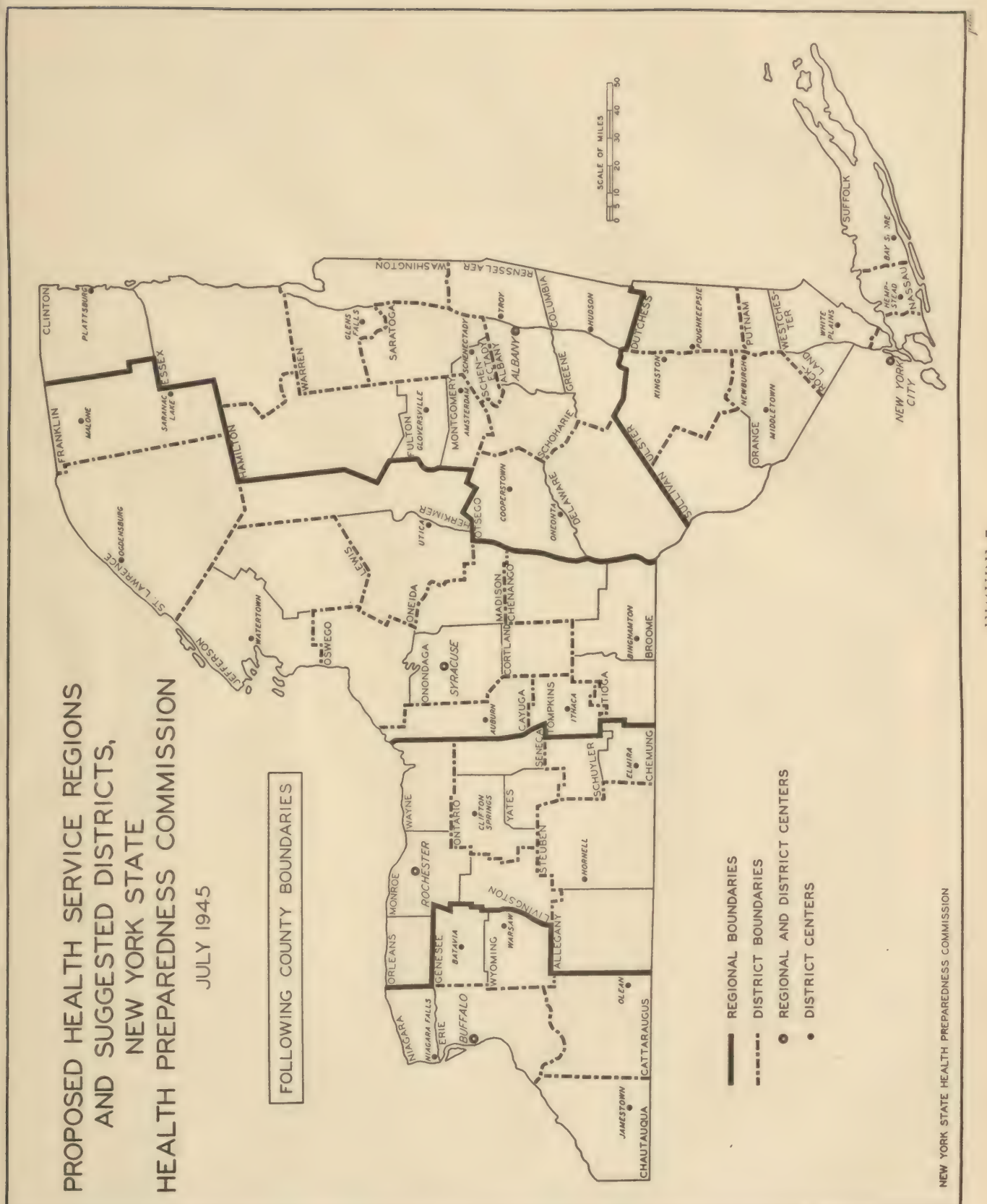
PROPOSED HEALTH SERVICE REGIONS
AND SUGGESTED DISTRICTS,
NEW YORK STATE
HEALTH PREPAREDNESS COMMISSION
JULY 1945
FOLLOWING COUNTY BOUNDARIES
REGIONAL BOUNDARIES
DISTRICT BOUNDARIES
REGIONAL AND DISTRICT CENTERS
DISTRICT CENTERS
SCALE OF MILES
0 5 10 20 30 40 50
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION
CLINTON
PLATTSBURG
FRANKLIN
MALONE
ESSEX
SARANAC LAKE
WARREN
GLENS FALLS
SARATOGA
WASHINGTON
RENSSELAER
TROY
COLUMBIA
HUDSON
DUTCHESS
POUGHKEEPSIE
PUTNAM
WESTCHESTER
WHITE PLAINS
SUFFOLK
BAY SHORE
HEMPSTEAD
NASSAU
NEW YORK CITY
LONG ISLAND
HAMILTON
FULTON
GLOVERSVILLE
MONTGOMERY
AMSTERDAM
SCHENECTADY
SCHENECTADY
ALBANY
ALBANY
GREENE
KINGSTON
ULSTER
NEWBURGH
ORANGE
MIDDLETOWN
SULLIVAN
ST. LAWRENCE
GOUVERNEUR
HERKIMER
UTICA
OTSEGO
COOPERSTOWN
SCHOHARIE
ONEIDA
DELAWARE
ONEONTA
JEFFERSON
WATERTOWN
LEWIS
OSWEGO
MADISON
CHENANGO
CORTLAND
ONONDAGA
SYRACUSE
BINGHAMTON
BROOME
CAYUGA
AUBURN
TOMPKINS
ITHACA
TIOGA
SENECA
SCHUYLER
ELMIRA
CHEMUNG
YATES
CLIFTON SPRINGS
ONTARIO
STEUBEN
HORNELL
WAYNE
MONROE
ROCHESTER
LIVINGSTON
ALLEGANY
WYOMING
WARSAW
GENESEE
BATAVIA
ORLEANS
NIAGARA
NIAGARA FALLS
ERIE
BUFFALO
OLEAN
CATTARAUGUS
JAMESTOWN
CHAUTAUQUA

FIGURE 7